

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7668

CERTIFICATE OF DEATH

07654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)			c. LENGTH OF STAY IN 1b 41 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk (22)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6734 Holabird Avenue				d. STREET ADDRESS 6734 Holabird Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle ++++ Last Abramowski				4. DATE OF DEATH Month July Day 25th Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1895	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber Shop Prop.				10b. KIND OF BUSINESS OR INDUSTRY Barbering (Men)		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Julian Abramowski				14. MOTHER'S MAIDEN NAME Julianna Ulko			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-32-7526		17. INFORMANT Address Mrs. Jean Abramowski same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 30 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 50 , to July 25 , 19 60 , that I last saw the deceased alive on July 23 , 19 60 , and that death occurred at 7:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 33 Dundalk Avenue DATE SIGNED 7/27/60							
ACTUAL SIGNATURE David H. Andrew M.D.				DATE SIGNED 7/27/60			
PHYSICIAN'S NAME (Type) David H. Andrew, M.D.				Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/60		22c. NAME OF CEMETERY OR CREMATORY Christ Lutheran Cmty.		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley Walter Brooks Bradley, Inc., Dundalk 22, Md.				24a. REC'D BY REGISTRAR JUL 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

7692

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07655

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 9 Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 14 South Bond Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLAUDE Middle ---- Last ALEXANDER		4. DATE OF DEATH Month JULY Day 12 Year 1960					
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9 1886	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Augusta, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Unkown				14. MOTHER'S MAIDEN NAME Unkown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clin. REc., VAH Balto 18, Md Ft Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UPPER RESPIRATORY HEMORRHAGE 162.1 DUE TO SQUAMOUS CARCINOMA OF BRONCHUS Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Abscess of anterior lower chest wall. 2. Arteriosclerotic cardio-vascular disease							
INTERVAL BETWEEN ONSET AND DEATH 5 min Undet.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Form 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 12:05AM				20g. (County)		20h. (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 11 1960 to July 12 1960 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 12 1960 , and that death occurred at 12:05AM , from the causes and on the date stated above.							
22a. SIGNATURE Walter J. Pijanowski				22b. DATE SIGNED 7/12/60			
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.				22d. ADDRESS VAH BALTIMORE 18, MD FT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-15-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Balto. Md	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O Wilson				ADDRESS 2004 Orleans St. Balto Md		25a. REC'D BY REGISTRAR DATE JUL 26 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

1880

CERTIFICATE OF DEATH

1880



DECEASED

DECEASED

TO BE FILLED

TO BE FILLED

WILLIAM ALBERTSON HOSPITAL

WILLIAM ALBERTSON HOSPITAL

DATE

DATE

TIME

TIME

PLACE

PLACE

OTHER INFORMATION

...

...

...

...

...

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
5
M
X
1

7693

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07656

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1 BOSLEY RD.			
3. NAME OF DECEASED (Type or print) WILLIAM RALPH ANDERSON				4. DATE OF DEATH JULY 28 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 2, 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VENTILIST				10b. KIND OF BUSINESS OR INDUSTRY DENTIST			
11. BIRTHPLACE (State or foreign country) GREENE COUNTY, MISSOURI				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LORENZO KING ANDERSON				14. MOTHER'S MAIDEN NAME JOSEPHINE EVANS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 486-44-4028			
17. INFORMANT Mrs. JOHN GEYER (DAUGHTER)				Address BOSLEY ROAD COCKEYSVILLE MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY FIBROSIS DUE TO (c) EMPHYSEMA							INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 10 YR 20 YR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (1) this hospital attended the deceased from 27 July 1960 to 28 July 1960 that (2) we last saw the deceased alive on 22 July 1960 and that death occurred on 28 July 1960 at 11 AM , from the causes and on the date stated above.							
22a. SIGNATURE Donald O. Wood, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/28/60	
22c. PHYSICIAN'S NAME (Type) DONALD O. WOOD M.D.				22d. ADDRESS YORK RD GREENMEADOW, TIMONIUM, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF AUG 15, 1960		23c. NAME OF CEMETERY OR CREMATORY MAPLE PARK CEMETERY		23d. LOCATION (City, town, or county) (State) GREENE COUNTY, MISSOURI	
24. FUNERAL DIRECTOR'S SIGNATURE HENRY W. JENKINS & SONS Co				ADDRESS 4905 YORK ROAD BALT 12.		25a. REC'D BY REGISTRAR JUL 29 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Evans			



CENTRAL BANK

7003

CERTIFICATE OF DEATH

07858

BATIMOS

DAITO

EXPIRATION DATE

DECEASED

DOLEY R

DOLEY R

JULY 25

JULY 25

3

TESTIMONY

TESTIMONY

CONSTITUTIONAL HISTORY

CONSTITUTIONAL HISTORY

CONSTITUTIONAL HISTORY

CONSTITUTIONAL HISTORY

CONSTITUTIONAL HISTORY

CONSTITUTIONAL HISTORY

CONSTITUTIONAL HISTORY

CONSTITUTIONAL HISTORY

Handwritten notes and signatures at the bottom of the page, including names like "D. B. B. B." and "J. B. B. B."

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7694 CERTIFICATE OF DEATH

07657

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3701.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 6320 Old Washington Rd. 331 S. Ann Street	
3. NAME OF DECEASED (Type or print) First PAUL Middle m.m.i. Last AREN		4. DATE OF DEATH Month July Day 1 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6.29.1893.
9. AGE (In years lost birthday) 67 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOE AREN		14. MOTHER'S MAIDEN NAME ANNIE SHEGRA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXXXXXX no		16. SOCIAL SECURITY NO. 180-03-3294	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced bilateral pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silicosis. Emphysema			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2.19.1957 to 7.1.1960 that I last saw the deceased alive on 7.1.1960 , and that death occurred at 3:16 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William Newcomer M.D.		M.D. Mt. Wilson State Hospital, Mt. Wilson, Md.	
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/60	
22c. NAME OF CEMETERY OR CREMATORY St. Augustines Cem.		22d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS Balta, Md.	
24a. REC'D BY REGISTRAR JUL 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Thoma	

STATE OF OHIO
DEPARTMENT OF HEALTH

1934

Ball's Cove, Kentucky

Dr. Wilson, Physician

Dr. Wilson, Physician

Dr. Wilson

Dr. Wilson

JOE AREN

ANNIE SHEPARD

12-03-34 Ball's Cove, Kentucky

xxxxxx no

Dr. Wilson, Physician

Dr. Wilson, Physician

Dr. Wilson, Physician

Dr. Wilson, Physician

Dr. Wilson, Physician

Dr. Wilson, Physician

Dr. Wilson, Physician

Dr. Wilson, Physician

Dr. Wilson, Physician

Dr. Wilson, Physician

Dr. Wilson, Physician

Dr. Wilson, Physician

7695

CERTIFICATE OF DEATH

07658

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1445 Burton Ave.				e. STREET ADDRESS 1445 Burton Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last William Grafton Barrett, Sr.				4. DATE OF DEATH Month Day Year 7-15 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-14-1905	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Hwys Dept. Balto. Maryland			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frederick G. Barrett				14. MOTHER'S MAIDEN NAME Mary Kelbaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 578-07-2610			
17. INFORMANT Mary Louise Barrett				18. ADDRESS above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Hypertensive Cardio-Renal Canditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vascular Disease DUE TO (c) 10 days				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 1, 1948 to July 12, 1960 that I last saw the deceased alive on July 12, 1960 , and that death occurred at 12:00 M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 7501 York Rd DATE SIGNED 7/15/60			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				PHYSICIAN'S NAME (Type) Charles F. O'Donnell MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-18-60		22c. NAME OF CEMETERY OR CREMATORY Poplar Grove	
22d. LOCATION (City, town, or county) (State) Cockeysville, Md.				23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.			
24a. REC'D BY REGISTRAR DATE JUL 20 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

03658

CERTIFICATE OF DEATH

1885

Locustville
 Locustville
 Maryland
 Baltimore

1445 Barton Ave.
 1445 Barton Ave.

William Crafton Bartlett, Sr.
 5-15-60
 5-14-1902
 White
 Foreman
 Hwy Dept. Bldg.
 Maryland
 U.S.A.

Frederick L. Bartlett
 578-07-2610 Mary Louise Bartlett
 above

Handwritten signatures and notes, including "C. Bartlett" and "Mary Louise Bartlett".

Handwritten notes and signatures at the bottom of the page.

Epworth Funeral Service, Towson, Md.
 5-15-60
 Epworth Grove
 Locustville, Md.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7696

CERTIFICATE OF DEATH

07659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amos Middle Garman Last Bechtel		4. DATE OF DEATH Month July Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1910
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Bechtel		14. MOTHER'S MAIDEN NAME Ada Garman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 204-07-6219	
17. INFORMANT Anna D. Bechtel, White Marsh, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March , 19 60 , to July , 19 60 , that I last saw the deceased alive on June 14 , 19 60 , and that death occurred at 5:30 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE William A. Tyson M.D.		ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 7-4-60	
PHYSICIAN'S NAME (Type) William A. Tyson, M.D.		Kingsville, Md. 7-4-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/7/60	22c. NAME OF CEMETERY OR CREMATORY West Greentree Cemetery, Elizabethtown, Penna.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring Address Tarring Funeral Home, Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE JUL 7 '60	24b. REGISTRAR'S SIGNATURE Charles S. Hance

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7678

CERTIFICATE OF DEATH

Reg. Dist. No.

07660

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 9. STATE <u>MD</u> St. Paul Street b. COUNTY <u>Maryland</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City, Md.</u> <u>3V01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Relay Hill Hospital</u>				d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>E.</u> Last <u>Berlin</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 3, 1887</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Claim agent - Western Maryland Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Berlin</u>				14. MOTHER'S MAIDEN NAME <u>Mary (b11111111) Keighley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				17. INFORMANT Address <u>Daughter: Mary Josephine Berlin Axelson</u> <u>5506- Fifth Ave; Pittsburg, 32, Penna. Apt. 207</u>			
16. SOCIAL SECURITY NO.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senile psychosis with schizoid personality</u> DUE TO (c) <u>1953</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>same as (c)</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 2</u> , 19 <u>53</u> , to <u>July 13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>60</u> , and that death occurred at <u>4:50A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Relay, 27, Md.</u> DATE SIGNED <u>7-13-60</u> ACTUAL SIGNATURE <u>James Castellano</u> M.D. PHYSICIAN'S NAME (Type) <u>James Castellano</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>7-14-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7686

CERTIFICATE OF DEATH

07661

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9607 DIXON AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROTH</u> Middle <u>ANN</u> Last <u>BISSELL</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 23 1890</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD H ROBERTS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH FOX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>ADA M. BRADY</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Old age Cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>?</u> 19 <u>56</u> to <u>JULY 29 1960</u> that I last saw the deceased alive on <u>JULY 28 1960</u> and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold H Burns</u> M.D.		ADDRESS (Street, city or town, state) <u>8106 Hartford Rd.</u> DATE SIGNED <u>7/29/60</u>	
PHYSICIAN'S NAME (Type) <u>Harold H Burns</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>August 1 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS. F. EVANS & SON</u> ADDRESS <u>8802 HARTFORD RD</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7697

CERTIFICATE OF DEATH

07662

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm, Md.</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Notch Cliff Manor, Glen Arm, Md.</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Victor C.</u> Middle <u>Blandin</u> Last <u></u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1887</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Rubber Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rubber Brkr</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Lt. John J. Blandin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Corrinne Sherbonnier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT Address <u>Mr. J. L. Capebianco, Orlando, Florida</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>July 11, 1960</u> to <u>July 12, 1960</u> , that I last saw the deceased alive on <u>July 11, 1960</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph F. Lipira</u> M.D.				ADDRESS (Street, city or town, state) <u>8450 Rock Haven Dr., Beltsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Joseph F. Lipira MD</u>				DATE SIGNED <u>7/12/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc. 1050 York Rd. Towson, 4, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneaf</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7698

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7mth10dys			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Herbert Middle Franklin Last Bloom				4. DATE OF DEATH Month July Day 17 Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1884	9. AGE in years last birthday 76 yrs.	10. UNDER 1 YEAR Months 7 Days 17	11. IF UNDER 24 HRS. Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) railroad		10b. KIND OF BUSINESS OR INDUSTRY Penn. R. R.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown Navy E. Ruhl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO (b) Hypertension Cardiac Vascular Disease DUE TO (c) accident fracture right leg PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Well leg traction applied on 7-6-60							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 6-29-60 pt. fell from bed sustaining intertrochanteric frac. of right femur					
20c. TIME OF INJURY Month, Day, Year 3:00 a.m. 6-29 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Catonsville 28, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George M. Kieffer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF July 29, 1960		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem. Balt. Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. T. Schwan				24a. REC'D BY REGISTRAR 20 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO FURNISH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a copy is necessary, please execute a duplicate certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7699

CERTIFICATE OF DEATH

Reg. Dist. No.

07664

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7709 Chestnut Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Howard</i> Middle <i>A.</i> Last <i>Boehm</i>		4. DATE OF DEATH Month <i>July</i> Day <i>7</i> Year <i>19 60</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-17-1892</i>
9. AGE (In years last birthday) yrs. <i>68</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Postman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Post Office</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Boehm</i>		14. MOTHER'S MAIDEN NAME <i>Zella Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>WW 1</i>	
17. INFORMANT <i>Mrs Irene L. Boehm</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>420.1</i> DUE TO <i>Cerebral Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO <i>Heart</i> (c) <i>Hypertension</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6/20 & 7/1</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/1</i> , 19 <i>60</i> , to <i>7-7-60</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>7-1-60</i> , 19 <i>60</i> , and that death occurred at <i>907</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Leonard J. Ruck</i> M.D.		PHYSICIAN'S NAME (Type) <i>Leonard J. Ruck</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>7-5-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 6 '60</i>	
ADDRESS <i>5305 Harford Rd.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

CERTIFICATE OF DEATH

1933

1933

(M)



(M)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7669

CERTIFICATE OF DEATH

Reg. Dist. No.

07665

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN TB 3 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res. 1971 Haselmere Road		e. STREET ADDRESS 1971 Haselmere Road	
3. NAME OF DECEASED (Type or print) HARRY EARL BOLTON		4. DATE OF DEATH Month July Day 21 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed in Shoe Repair Shop		10b. KIND OF BUSINESS OR INDUSTRY Virginia	9. AGE (In years last birthday) yrs. 58
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Bolton		14. MOTHER'S MAIDEN NAME Cornelia Bolton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 224-09-4988	
17. INFORMANT Mrs. Harry E. Bolton		Address 1971 Haselmere Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC C.V. DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
21. I certify that I attended the deceased from Jan 20, 1960 , to Jan 21, 1960 , that I last saw the deceased alive on Jan 20, 1960 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE Stephen C. Mackowiak M.D.			DATE SIGNED 7-21-60
PHYSICIAN'S NAME (Type) STEPHEN C. MACKOWIAK			6714 HOLBROOK AVE BALTIMORE 22 MD
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-23-1960	22c. NAME OF CEMETERY OR CREMATORY St. Jacobs	22d. LOCATION (City, town, or county) (State) Rockingham Co. Virginia
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		24a. REC'D BY REGISTRAR JUL 25 '60	
ADDRESS 7922 Wise Ave. 22, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

100-10000

<p>1. Name of deceased: <u>JOHN J. HARRIS</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1895</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1945</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1945</u></p>		<p>12. Place of registration: <u>NEW YORK</u></p>	
<p>13. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>14. Address of informant: <u>NEW YORK</u></p>	
<p>15. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>16. Address of informant: <u>NEW YORK</u></p>	
<p>17. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>18. Address of informant: <u>NEW YORK</u></p>	
<p>19. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>20. Address of informant: <u>NEW YORK</u></p>	
<p>21. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>22. Address of informant: <u>NEW YORK</u></p>	
<p>23. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>24. Address of informant: <u>NEW YORK</u></p>	
<p>25. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>26. Address of informant: <u>NEW YORK</u></p>	
<p>27. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>28. Address of informant: <u>NEW YORK</u></p>	
<p>29. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>30. Address of informant: <u>NEW YORK</u></p>	
<p>31. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>32. Address of informant: <u>NEW YORK</u></p>	
<p>33. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>34. Address of informant: <u>NEW YORK</u></p>	
<p>35. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>36. Address of informant: <u>NEW YORK</u></p>	
<p>37. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>38. Address of informant: <u>NEW YORK</u></p>	
<p>39. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>40. Address of informant: <u>NEW YORK</u></p>	
<p>41. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>42. Address of informant: <u>NEW YORK</u></p>	
<p>43. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>44. Address of informant: <u>NEW YORK</u></p>	
<p>45. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>46. Address of informant: <u>NEW YORK</u></p>	
<p>47. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>48. Address of informant: <u>NEW YORK</u></p>	
<p>49. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>50. Address of informant: <u>NEW YORK</u></p>	
<p>51. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>52. Address of informant: <u>NEW YORK</u></p>	
<p>53. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>54. Address of informant: <u>NEW YORK</u></p>	
<p>55. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>56. Address of informant: <u>NEW YORK</u></p>	
<p>57. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>58. Address of informant: <u>NEW YORK</u></p>	
<p>59. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>60. Address of informant: <u>NEW YORK</u></p>	
<p>61. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>62. Address of informant: <u>NEW YORK</u></p>	
<p>63. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>64. Address of informant: <u>NEW YORK</u></p>	
<p>65. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>66. Address of informant: <u>NEW YORK</u></p>	
<p>67. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>68. Address of informant: <u>NEW YORK</u></p>	
<p>69. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>70. Address of informant: <u>NEW YORK</u></p>	
<p>71. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>72. Address of informant: <u>NEW YORK</u></p>	
<p>73. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>74. Address of informant: <u>NEW YORK</u></p>	
<p>75. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>76. Address of informant: <u>NEW YORK</u></p>	
<p>77. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>78. Address of informant: <u>NEW YORK</u></p>	
<p>79. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>80. Address of informant: <u>NEW YORK</u></p>	
<p>81. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>82. Address of informant: <u>NEW YORK</u></p>	
<p>83. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>84. Address of informant: <u>NEW YORK</u></p>	
<p>85. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>86. Address of informant: <u>NEW YORK</u></p>	
<p>87. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>88. Address of informant: <u>NEW YORK</u></p>	
<p>89. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>90. Address of informant: <u>NEW YORK</u></p>	
<p>91. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>92. Address of informant: <u>NEW YORK</u></p>	
<p>93. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>94. Address of informant: <u>NEW YORK</u></p>	
<p>95. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>96. Address of informant: <u>NEW YORK</u></p>	
<p>97. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>98. Address of informant: <u>NEW YORK</u></p>	
<p>99. Name of informant: <u>JOHN J. HARRIS</u></p>		<p>100. Address of informant: <u>NEW YORK</u></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE		c. LENGTH OF STAY IN 1b 3 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) COLLEGE MANOR		d. STREET ADDRESS CHARLES & 33rd STREET	
3. NAME OF DECEASED (Type or print) First Middle Last AGUSTA BRANDAU		4. DATE OF DEATH Month Day Year JULY 13, 1960 19	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 7, 1877
9. AGE (in years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MARTIN MAYFORT		14. MOTHER'S MAIDEN NAME CATHERINE KNIER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MR. A. GORDON BRANDAU		1646 Roundhill Road Balto. 18 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 979x Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis due to Plaque (c) Bag tied over head to Commit Suicide PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden		INTERVAL BETWEEN ONSET AND DEATH 40 hrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles F O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/13/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) XXXXXX		22b. DATE THEREOF JULY 16, 1960	
22c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CREMATORY		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.		24a. REC'D BY REGISTRAR DATE JUL 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07667

7701

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Bradshaw</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air RD 2</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Rural 12X-2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Graham</u> Middle <u>B</u> Last <u>Brown</u>		4. DATE OF DEATH		Month <u>7</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 18 - 1943</u>	
9. AGE (In years last birthday) <u>17</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>Fallston -</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Graham Brown Jr</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Graham Brown Jr</u> Address <u>Bel Air RD 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>421.1 Biotic Stenosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Wm. J. [Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-3-60</u>	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tabernacle</u>		22d. LOCATION (City, town, or county) _____ (State) <u>Benson, Hfd. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>evn Archer, Benson, Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Orlando S. [Signature]</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

VR A15 (4)
15M 9/59

1
7702
M
650
I
2
1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07668

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 27 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 900 CATHEDRAL STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle W Last BURGESSER		4. DATE OF DEATH Month JULY Day 17 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MARCH 15, 1892
9. AGE (In years lost birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 01 Hours 01 Min. 4	11. IF UNDER 24 HRS. Months 01 Days 01 Hours 01 Min. 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE BROKER		10b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME RAYMOND W. BURGESSER, SR		14. MOTHER'S MAIDEN NAME NANCY RICHARDSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 214-09-6651	
17. INFORMANT CLIN REC., VAH BALTO 18, MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) 420-1 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertrophy and dilatation of heart; Cardiac Decompensation; Diabetis Mellitus; Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 20 11:30 PM to July 17 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 17 1960 , and that death occurred at 11:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Walter J. Pijanowski		22b. DATE 7/19/60	
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.		22d. ADDRESS VAH BALTO 18, MD FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-21-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight Inc. 6009 Harford Rd Balto Md		25a. REC'D BY REGISTRAR JUL 22 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1303

CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

WITNESSES: [illegible]

REGISTRATION: [illegible]

[illegible text]

7703

CERTIFICATE OF DEATH

07669
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baynesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baynesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8616 Oakleigh Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr. John Michael Burke</i>		4. DATE OF DEATH <i>July 21st 19 60</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 31, 1894</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Boiler Maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Patrick Burke</i>		14. MOTHER'S MAIDEN NAME <i>Catherine ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>INFORMANT Mrs. Anne M. Burke</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lungs.</i> DUE TO <i>metastases to brain</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardiovascular disease</i> DUE TO (c) <i>Cardiovascular disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 20, 1959</i> to <i>July 21, 1960</i> , that I last saw the deceased alive on <i>July 20, 1960</i> , and that death occurred at <i>16 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Leonard Y. Ruck</i> M.D.		ADDRESS (Street, city or town, state) <i>8402 Greenwood Rd Baltimore, Md</i> DATE SIGNED <i>7/22/60</i>	
PHYSICIAN'S NAME (Type) <i>Leonard Y. Ruck, M.D.</i>		<i>Leonard Y. Ruck</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/25/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard Y. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>DATE JUL 25 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1907



1

[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Age, Sex, Date of Birth, Date of Death, Cause of Death, and Place of Death. There are also lines for the signature of the attending physician and the registrar.]

7704

CERTIFICATE OF DEATH

Reg. Dist. No.

07670

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. LENGTH OF STAY IN 1b X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broadway Road				d. STREET ADDRESS Broadway Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Thomas Last Burnham				4. DATE OF DEATH Month July Day 10 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 19, 1896	
9. AGE (In years lost birthday) 63		IF UNDER 1 YEAR Months 6 Days 3 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Baltimore County	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas C. Burnham				14. MOTHER'S MAIDEN NAME Maryl L. Harmon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. W.W.I			
17. INFORMANT Mrs. Frank Tangney, Broadway Road, Lutherville				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Coma DUE TO Hypertension + arteriosclerosis (b) Diabetes DUE TO chronic glomerular nephritis (c) 3 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), or (c). 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs. 10 yrs. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 7-9-19 p. m. 30				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 7A.M.	
20f. (City or town) Baltimore (County) MD (State) MD							
21. I certify that I attended the deceased from 7-9-19 to 7-10-60 , that I last saw the deceased alive on 7-9-19 , and that death occurred at 7A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md DATE SIGNED 7-11-60 ACTUAL SIGNATURE James G. Saffell M.D. Reisterstown, Md PHYSICIAN'S NAME (Type) James G. Saffell MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 7-13-60		22c. NAME OF CEMETERY OR CREMATORY Saters Baptist Cemetery	
22d. LOCATION (City, town, or county) Baltimore County, Md (State) MD							
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Ok-Towson, Inc., 1050 York Rd. Towson				24a. REC'D BY REGISTRAR JUL 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

03070

CERTIFICATE OF DEATH

1905

[Faint, mostly illegible text and markings on a form, possibly a death certificate or official document. The text is mirrored and difficult to decipher.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7705
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07671

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) COCKEYSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARCIA Middle BURNHAM Last BURNHAM		4. DATE OF DEATH Month JULY Day 18 Year 1960	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-1871
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES GOODWIN		14. MOTHER'S MAIDEN NAME MARY GRIFFIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-16-5907-1	
17. INFORMANT Frank E. Smith Jr. - Cockeysville, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) 5 years. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-9 19 55 to 7-18 19 60 , that (I) (we) lost saw the deceased alive on 7-15 19 60 , and that death occurred at 1:35 PM , from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees		22b. DATE SIGNED 7/18/60	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-20-60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE William C. Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR JUL 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frame			

1705

CERTIFICATE OF DEATH

01001

MARRIED

BALTIMORE

BALTIMORE

7 YEARS

COCKEYVILLE

2905 GATLINSON AVE

11400 W. HOME

DATE OF DEATH: JANUARY 12, 1981
AGE: 3-11-1871

THOMAS AND

ROSEMARY

JAMES GEORGE WILSON

11400 W. HOME, BALTIMORE, MARYLAND
11400 W. HOME, BALTIMORE, MARYLAND

11400 W. HOME, BALTIMORE, MARYLAND
11400 W. HOME, BALTIMORE, MARYLAND

11400 W. HOME, BALTIMORE, MARYLAND
11400 W. HOME, BALTIMORE, MARYLAND

11400 W. HOME, BALTIMORE, MARYLAND
11400 W. HOME, BALTIMORE, MARYLAND

7706

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 30			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 639 E. Clement Str.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAWRENCE First ALBERT Middle BURNS Last				4. DATE OF DEATH July Month 19 Day 1960 Year			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4. 1880	
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOHN J. BURNS				14. MOTHER'S MAIDEN NAME MARY R. REED			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown If yes, give war or dates of service				16. SOCIAL SECURITY NO. Unknown			
INFORMANT				Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 yrs +							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far Advanced Pulmonary TB. Acute left Pyelonephritis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12. 1. 1959 to 7. 19 1960 that I last saw the deceased alive on 7. 19 1960 , and that death occurred at 8:37 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED _____ ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-22-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Bethesda Md	
23. FUNERAL DIRECTOR'S SIGNATURE McCall's Funeral Home ADDRESS 130 E. Baltimore				24a. REC'D BY REGISTRAR DATE JUL 22 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1106

CERTIFICATE OF DEATH

1106



Residence of Deceased

St. Louis, Missouri

St. Louis, Missouri

LAWRENCE

ALBERT BURNS

July 19 1880

M. W.

X

Witness

JOHN J. BURNS

MARY R. REED

Witness

Witness

And the undersigned

24

For Attestation

12. 1. 1880

St. Louis, Missouri

Notary Public

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

7707

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07673

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE CONNECTICUT b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 15 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 44 HILLSBORO DRIVE	
3. NAME OF DECEASED (Type or print) First EDWIN Middle W Last BURRITT		4. DATE OF DEATH Month JULY Day 12 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 17 1888
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIL ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) WYOMING		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CHARLES H BURRITT		14. MOTHER'S MAIDEN NAME CLARA E WHEELER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 578 32 5110	
17. INFORMANT CLIN REC. VAH BALTO 18, MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA RIGHT LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS, RIGHT DUE TO (c) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 15 DAYS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 27 12:15 PM to July 12 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 12 1960 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Walter J. Pijanowski		22b. DATE SIGNED 7/13/60	
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.		22d. ADDRESS VAH FT HOWARD DIVISION, BALTO, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-16-60	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		25a. REC'D BY REGISTRAR JUL 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna		25c. ADDRESS 4600 Liberty Heights Ave Balto MD	

DECLARATION OF DEATH

7503

COMMISSIONER

DEPARTMENT

STATE OF NEW YORK

IN SENATE

FOR FILING

STATE OF NEW YORK

IN SENATE

DEPARTMENT

STATE

STATE OF NEW YORK

DEPARTMENT

U.S.A.

STATE

DEPARTMENT

STATE OF NEW YORK

DEPARTMENT

STATE OF NEW YORK

DEPARTMENT

STATE

STATE

DEPARTMENT

STATE

DEPARTMENT

STATE

DEPARTMENT

STATE

DEPARTMENT

STATE

DEPARTMENT

STATE

STATE OF NEW YORK

DEPARTMENT

STATE OF NEW YORK

DEPARTMENT

STATE

STATE OF NEW YORK

DEPARTMENT

STATE OF NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7708

CERTIFICATE OF DEATH

Reg. Dist. No.

07674

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 954 Renfrew Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosy Middle +++ Last BUTLER		4. DATE OF DEATH Month July Day 8th , Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1882
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) South Wales		12. CITIZEN OF WHAT COUNTRY? So. Wales	
13. FATHER'S NAME James Temblett		14. MOTHER'S MAIDEN NAME Sarah Ann Hatch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Bertram Butler		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral thrombosis DUE TO 3 mos (c) Generalized arteriosclerosis DUE TO 2 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1 , 19 60 , to 7/8 , 19 60 , that I last saw the deceased alive on 7/1 , 19 60 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 434 Eastern Blvd. DATE SIGNED 8/9/60 ACTUAL SIGNATURE J. J. Platt M.D. PHYSICIAN'S NAME (Type) J. J. Platt, M.D. Essex 21, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/60	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Brooks Bradley		ADDRESS Dundalk 22, Md.	
24a. REC'D BY REGISTRAR DATE JUL 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

CERTIFICATE OF DEATH

1908

1908

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
John J. Smith		Male		45		Jan 1, 1863		Boston, Mass.	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
MARRIED		SINGLE		MARRIED		DIVORCED		WIDOWED	
DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
Jan 1, 1908		Boston, Mass.		Jan 1, 1908		Boston, Mass.		Heart Disease	
OCCUPATION		PROFESSION		EDUCATION		RELIGION		RACE	
Clerk		Clerk		High School		Roman Catholic		White	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISON	
None		None		None		None		None	
PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OPIUM		PREVIOUS MARIJUANA	
None		None		None		None		None	
PREVIOUS FEVER		PREVIOUS PNEUMONIA		PREVIOUS TUBERCULOSIS		PREVIOUS DIARRHEA		PREVIOUS COLIC	
None		None		None		None		None	
PREVIOUS ASTHMA		PREVIOUS BRONCHITIS		PREVIOUS EMPHYSEMA		PREVIOUS ANGINA		PREVIOUS MYOCARDIAL INFARCTION	
None		None		None		None		None	
PREVIOUS RHEUMATISM		PREVIOUS GOUT		PREVIOUS GRAVEL		PREVIOUS CALCULI		PREVIOUS HEMIPLEGIA	
None		None		None		None		None	
PREVIOUS PARALYSIS		PREVIOUS CONVULSIONS		PREVIOUS EPILEPSY		PREVIOUS HYSTERIA		PREVIOUS NEURALGIA	
None		None		None		None		None	
PREVIOUS SCURVY		PREVIOUS BERBERI		PREVIOUS SYPHILIS		PREVIOUS GONORRHOEA		PREVIOUS CHANCER	
None		None		None		None		None	
PREVIOUS LEPROSY		PREVIOUS TUBERCULOSIS		PREVIOUS SYPHILIS		PREVIOUS GONORRHOEA		PREVIOUS CHANCER	
None		None		None		None		None	
PREVIOUS SCURVY		PREVIOUS BERBERI		PREVIOUS SYPHILIS		PREVIOUS GONORRHOEA		PREVIOUS CHANCER	
None		None		None		None		None	
PREVIOUS LEPROSY		PREVIOUS TUBERCULOSIS		PREVIOUS SYPHILIS		PREVIOUS GONORRHOEA		PREVIOUS CHANCER	
None		None		None		None		None	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07675

7709

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore M. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Butler Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Vincent First Talbott Middle Caples Sr. Last		4. DATE OF DEATH Month July Day 13 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1872
9. AGE (In years and birth day) 87 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert F. Caples		14. MOTHER'S MAIDEN NAME Elizabeth Shipley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Robert Caples Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic C-V Disease 9 yrs. (c) Diabetes 23 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none p. m. 9		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 11-20-37 , 19____, to 7-13-60 , 19____, that I last saw the deceased alive on 7-13-60 , 19____, and that death occurred at 5 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Road DATE SIGNED 7-15-60			
ACTUAL SIGNATURE D. D. Caples		M.D. Reisterstown, Md.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 16, 1960	22c. NAME OF CEMETERY OR CREMATORY Dover Cemetery	22d. LOCATION (City, town, or county) (State) Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE JUL 18 '60	
ADDRESS J. F. Eline & Sons Reisterstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

03025

CERTIFICATE OF DEATH

4503



1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

07676

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Conv.Home.				d. STREET ADDRESS Formerly of 325 Yale Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David L. Carter		First Middle Last		4. DATE OF DEATH July 25, 1960		Month Day Year	
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28, 1882	
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY Pa. R.R.		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME -----Carter				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr Allan Gunter, Box 82, Pratt W.Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 432.11 DUE TO arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/10 1960 to 7/25 1960 , that (I) (we) lost saw the deceased alive on 7/25 1960 and that death occurred at 6:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Theodore T. Witzke M.D.		22b. PHYSICIAN'S NAME (Type) Theodore T. Witzke M.D.		22c. ADDRESS 429 S Chester St Md.		22d. DATE SIGNED 7/26/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/60		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Centy.		23d. LOCATION (City, town, or county) (State) Woodlawn Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke Fun. Dir. 4101 Edmondson Ave		25a. REC'D BY REGISTRAR DATE JUL 27 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Krueger			

CERTIFICATE OF DEATH

Inf. Name

Residence

Shady Brook Cemetery, formerly of 333 Yale Ave

David T.

Age

July

80

Londoner

Age

Age

Age

-----Died

Unknown

Mr. John J. Jones, Box 88, First W. Va.

Witness

Witness

1

N
910
1
0
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7711

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07677

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Attington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shady Nook Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>BERTHA</i> Middle <i>M.</i> Last <i>CHIPMAN</i>		4. DATE OF DEATH Month <i>July</i> Day <i>7</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 29 1877</i>
9. AGE (In years last birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Funtsville Harford Co.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George W. Streett</i>		14. MOTHER'S MAIDEN NAME <i>Margaret E. Mason</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16. SOCIAL SECURITY NO. <i>No.</i>	
17. INFORMANT Address <i>Mrs. Ellwood M. Campbell</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arterio Sclerosis 50 yrs</i> DUE TO (c) <i>Myocarditis - Corrupt Emboli</i> 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 5 1960</i> to <i>July 7 1960</i> , that (I) (we) last saw the deceased alive on <i>July 7 1960</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Wetherbeer Fort</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Wetherbeer Fort</i>		22d. ADDRESS <i>1118 St. Paul St. Balto. Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7-90-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins & Sons, Co.</i>		25. REC'D. BY REGISTRAR <i>Jul 12 1960</i>	
ADDRESS <i>4905 York Road</i>		25b. REGISTRAR'S SIGNATURE <i>Robert D. Thomas</i>	

1

7712

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07678

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 12 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PURR Middle LEE Last CHOATE				4. DATE OF DEATH Month JULY Day 18 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1916	
9. AGE (In years lost birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY Barber Shop		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME PURR LEE CHOATE, SR.				14. MOTHER'S MAIDEN NAME DAISY BEECKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES PTE				16. SOCIAL SECURITY NO. 214-12-7311		17. INFORMANT CLIN. RECORDS VA HOSP BALTO MD FT HOWARD DIV	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PORTAL CIRRHOSIS OF THE LIVER BLEEDING ESOPHAGEAL VARICES				INTERVAL BETWEEN ONSET AND DEATH 1 DAY UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GASTRITIS AND DUODENATIS				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (a) (this hospital) attended the deceased from July 6 19 60 to July 18 19 60 that (b) (he) last saw the deceased alive on July 18 19 60 and that death occurred at 6:35 AM from the causes and on the date stated above.							
22a. SIGNATURE Walter J. Pijanowski				22b. DATE SIGNED 7/18/60			
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.				22d. ADDRESS VAH BALTO MD. FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-21-60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck Funeral Home				25a. REC'D BY REGISTRAR 5305 Harford Rd. Balto. Md.		25b. REGISTRAR'S SIGNATURE Charles L. Evans	

05078

13

CERTIFICATE OF STATE

1915

RECEIVED

1

STATE BOARD

IN DEPT

RECEIVED

THE STATE ADMINISTRATIVE BOARD

BY E. H. HARRIS, Secretary

DATE: JULY 15, 1915

CERTIFICATE

NO.

1915

STATE OF NORTH CAROLINA

BEFORE ME, the undersigned authority, on this day personally appeared

W. A. A.

and acknowledged to me that he executed the foregoing instrument for the purposes and consideration therein expressed.

Given under my hand and seal of office this day of July, 1915.

1

Notary Public in and for the State of North Carolina

1915

1915

NOTARY PUBLIC

NOTARY

NOTARY

NOTARY PUBLIC

1915

NOTARY PUBLIC

NOTARY

NOTARY

NOTARY

NOTARY

NOTARY

NOTARY

NOTARY

NOTARY

NOTARY

NOTARY PUBLIC

NOTARY

NOTARY

NOTARY

NOTARY

NOTARY PUBLIC

NOTARY

NOTARY

NOTARY

NOTARY PUBLIC

NOTARY

NOTARY

NOTARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
7713
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07679

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 21 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V 01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 5203 ELMER AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEO Middle J Last CHRISTIE				4. DATE OF DEATH Month July Day 29 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 20, 1895	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TENNIS INSTRUCTOR		10b. KIND OF BUSINESS OR INDUSTRY COUNTRY CLUB		11. BIRTHPLACE (State or foreign country) LOWELL, MASSACHUSETTS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos Christie				14. MOTHER'S MAIDEN NAME Eugenia Nerrineau			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW L		17. INFORMANT Address Clin. Rec. Vet Adm Hosp Balto 18, Md Ft. Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 193.0 DUE TO LOBAR PNEUMONIA LEFT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. } (b) GLIOMA OF THE LEFT FRONTAL LOBE OF THE BRAIN (c) Unknown						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 8 10:00AM to July 29 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 29 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Walter J. Pijanowski				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/29/60	
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M. D.				22d. ADDRESS VAH Balto 18, Md Ft Howard Division			
23a. BURIAL-CREMATATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/2/60		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C. Vernon Lemmon				ADDRESS 4611 Park Heights Ave Balto. Md		25a. REC'D BY REGISTRAR DATE AUG 1 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7714

CERTIFICATE OF DEATH

Reg. Dist. No. 07680

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>A.A.Co.</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severn</i> 02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in the Pines - Nursing Home</i>		d. STREET ADDRESS <i>Box - 99 - Rt - #2</i>	
3. NAME OF DECEASED (Type or print) First <i>Nora</i> Middle <i>Clark</i> Last <i>Clark</i>		4. DATE OF DEATH Month <i>July</i> Day <i>3</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 28 - 1888</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Woman Officer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Reformatory</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Asberry Clark</i>		14. MOTHER'S MAIDEN NAME <i>Anna L. Pay</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Hypertensive Cardio-Vascular Disease</i> DUE TO (c) <i>10 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/12</i> , 19 <i>60</i> , to <i>7/3</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>7/2</i> , 19 <i>60</i> , and that death occurred at <i>1:15</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6209 Frederick Ave.</i> DATE SIGNED <i>7/3/60</i>			
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i> M.D.			
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher M.D.</i>		<i>Baltimore - 28 Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-6-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Friendship Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>A.A.Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert K. Ware</i> ADDRESS <i>Singleton Funeral Home - Robert K. Ware</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 7 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi		6. RACE White		7. MARITAL STATUS Single		8. OCCUPATION None		9. PRESENT RESIDENCE Room 304, 400 North Dearborn St., Memphis, Tenn.		10. DATE OF DEATH Apr 4, 1968		11. PLACE OF DEATH Memphis, Tenn.		12. CAUSE OF DEATH FIRE		13. MANNER OF DEATH Accident		14. SIGNATURE OF DECEASED None		15. SIGNATURE OF WITNESS None		16. SIGNATURE OF PHYSICIAN None		17. SIGNATURE OF CORONER None		18. SIGNATURE OF JURY None		19. SIGNATURE OF DISTRICT ATTORNEY None		20. SIGNATURE OF CLERK None	
---------------------------------------	--	----------------	--	--------------	--	---------------------------------	--	---	--	------------------	--	-----------------------------	--	-----------------------	--	--	--	----------------------------------	--	--------------------------------------	--	----------------------------	--	---------------------------------	--	-----------------------------------	--	----------------------------------	--	------------------------------------	--	----------------------------------	--	-------------------------------	--	--	--	--------------------------------	--

1. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

2. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

3. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

4. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

5. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

6. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

7. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

8. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

9. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

10. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

11. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

12. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

13. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

14. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

15. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

16. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

17. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

18. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

19. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

20. I hereby certify that the above is a true and correct statement of the facts and circumstances surrounding the death of the deceased named herein.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7714 BAGLEY AVE.				d. STREET ADDRESS 321 SMALL COURT,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last EMMA DIETRICH CLASSEN				4. DATE OF DEATH Month Day Year JULY 13, 1960			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 11, 1893	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY D.H.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME DIETRICH				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address JOHN A. DIETRICH, 321 SMALL COURT, CATONSVILLE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arterio sclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH Many yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 9, 1960 to July 13, 1960 , that (I) (we) last saw the deceased alive on July 9, 1960 , and that death occurred at 1960 M, from the causes and on the date stated above.							
22a. SIGNATURE William H. Hines				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/15/60	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 3100 Harford Road, Baltimore, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
BURIAL		JULY 16/60		LODGE PARK		BALTO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WITKE FUN. DIR, 4101 EDMONDSON AVE.				25a. REC'D BY REGISTRAR DATE JUL 18 1960		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

1115

1115

BALTIMORE

CHINA DISTRICT

1301 BUCKLEY AVE

CHINA DISTRICT

1115

1115

1115

1

1115

1115

1115

1115

1115

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 7716
 CERTIFICATE OF DEATH

07682
 Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 43 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 621 Pennsylvania Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Louie Freeman Cole				4. DATE OF DEATH Month 7 Day 4 Year 1960			
5. SEX M		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/18/1906	
9. AGE (In years last birthday) 54 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Mfg. Plant		11. BIRTHPLACE (State or foreign country) W. Va	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Charles Cole			
14. MOTHER'S MAIDEN NAME Flora Madden				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service) None			
16. SOCIAL SECURITY NO. 198-03-8853				INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of chest wall 1979-1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that I attended the deceased from 5/20 , 19 60 to 7/4 , 19 60 , that I lost sow the deceased olive on 7/4 , 19 60 , and that death occurred at 12:30 AM , from the causes ond on the dote stoted above. A.M. ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE William Newcomer				M.D. Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal + Burial		7/9/60		Duffields Cemetery		Reedson Jefferson Co., West Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Cables				ADDRESS Harpers Ferry, W. Va.		24a. REC'D BY REGISTRAR DATE JUL 7 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

0700

CERTIFICATE OF DEATH

1157

(M)

St. Louis County

St. Louis, Missouri

St. Louis State Hospital

Male

White

Single

Charles Cole

Age 45

Occupation

Cause of Death

Place of Death

Time of Death

Signature

Date

Witness

Registrar

Medical Officer

Coroner

Official Seal

07683

CERTIFICATE OF DEATH

7517



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
7718					07684				
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson c. LENGTH OF STAY IN 1b 20 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland d. STREET ADDRESS none e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Helen Middle M. Last Cone					4. DATE OF DEATH Month 7 Day 29 Year 19 60				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/7/08		9. AGE (In years last birthday) 52 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hospital attendant		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Rochester, New York			12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Fred. E. Cone					14. MOTHER'S MAIDEN NAME ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-38-3209		17. INFORMANT Address Records on file at Mt. Wilson State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) hypertension. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis, inactive.									INTERVAL BETWEEN ONSET AND DEATH 2 3/4 hours 10 years.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 23 1960 to July 29 1960 , that (I) (we) last saw the deceased alive on July 29 1960 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.									
22a. SIGNATURE William Newcomer					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/29/60		
22c. PHYSICIAN'S NAME (Type) WILLIAM NEWCOMER, M. D.					22d. ADDRESS Mt. Wilson, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE THEREOF 7/31/60		23c. NAME OF CEMETERY OR CREMATORY Savania Cemetery			23d. LOCATION (City, town, or county) (State) Greene New York		
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Krause Funeral Home 1216 S. Charles S					25a. REC'D BY REGISTRAR DATE AUG 1 '60		25b. REGISTRAR'S SIGNATURE Charles S. Krause		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7719

07685

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 65 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle F. Last COOPER				4. DATE OF DEATH Month JULY Day 2 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/12/94	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Doctor				10b. KIND OF BUSINESS OR INDUSTRY Physician			
11. BIRTHPLACE (State or foreign country) Kansas City, Missouri				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Calvin L. Cooper				14. MOTHER'S MAIDEN NAME Mary Shannon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 123-03-8774			
17. INFORMANT Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASTROCYTOMA GRADE III LEFT FRONTAL REGION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 28, 1960 , to July 2, 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 2, 1960 , and that death occurred at 2 AM , from the causes and on the date stated above.							
22a. SIGNATURE <i>George C. McEneaney</i> GEORGE C. MCEANEAY				22b. DATE SIGNED 7/2/60			
22c. PHYSICIAN'S NAME (Type) VAH, BALTO. 18, MD. FT. HOWARD DIVISION				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 7-6-60			
23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				25a. REC'D BY REGISTRAR 6009 Harford Road Baltimore 14, Maryland			
25b. REGISTRAR'S SIGNATURE DATE JUL 6 '60				25c. REGISTRAR'S SIGNATURE Arthur S. Hines			

45

..

7670

CERTIFICATE OF DEATH

07686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1902 Snyder Ave. # 22.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle M. Last COSGROVE		4. DATE OF DEATH Month July Day 17 , Year 19 60.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept., 17, 1886.
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 7 Days 17 Hours 19 Min.	11. IF UNDER 24 HRS. Months 7 Days 17 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Erie, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Casper Roman		14. MOTHER'S MAIDEN NAME Agnes Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Marie A. Pollhein		Address Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO Coronary heart failure Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Coronary heart failure DUE TO Coronary heart failure (c) Coronary heart failure			INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-13 , 19 60 , to 7-16 , 19 60 that I last saw the deceased alive on 7-13 , 19 60 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack P. Collins M.D.		ADDRESS (Street, city or town, state) 3 Kinsship DATE SIGNED 7-18-60	
PHYSICIAN'S NAME (Type) JACK P. COLLINS		BALTO. 22	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-20 -60.	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) 7225 Eastern Blvd., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Seiler		24a. REC'D BY REGISTRAR 6224 EASTERN AVE, BALTO., 24, MD.	24b. REGISTRAR'S SIGNATURE Jul 20 '60

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7720

07687

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 10 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Mechanicsville			
3. NAME OF DECEASED (Type or print) First LORENZO Middle D. Last CROUSE				4. DATE OF DEATH Month JULY Day 1 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/92	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Saginaw, Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		17. INFORMANT Clin. Rec. VAH, Balto 18, Md. Ft. Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE (PULMONARY EDEMA) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH 10 DAYS 1 MONTH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from June 21 19 60 , to July 1 19 60 , that (I) (we) last saw the deceased alive on July 1 19 60 , and that death occurred at 9:40 PM from the causes and on the date stated above.							
22a. SIGNATURE George C. McElpatrick		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH, BALTO 18, MD. FT. HOWARD DIVISION		22b. DATE SIGNED 7/2/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/5/60		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cem.		23d. LOCATION (City, town, or county) (State) Morganza, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robinson Funeral Home,				25a. REC'D BY REGISTRAR DAUL 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

(M)

(1)

[Handwritten signature]

[Vertical stamp: RECEIVED]

[Vertical stamp: JUN 1964]

7721

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Villa Nova</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Villa Nova, Baltimore 7,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4000 Bedford Road, Baltio. 7, Md.</u>		d. STREET ADDRESS <u>4000 Bedford Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>D'Adamo</u> Last <u>D'Adamo</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7,</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min. <u>67</u>	IF UNDER 24 HRS. Months <u>67</u> Days <u>67</u> Hours <u>67</u> Min. <u>67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D'Adamo Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Vasto, Italy</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Pasquale D'Adamo</u>		14. MOTHER'S MAIDEN NAME <u>Anna Maria Calenza</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W. 1</u>		16. SOCIAL SECURITY NO. <u>213-30-4525</u>	
INFORMANT <u>Mrs. Mary C. D'Adamo</u>		Address <u>Baltimore 7, Md.</u> <u>4000 Bedford Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 260X DUE TO (b) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u> <u>several yrs</u> <u>few years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>60</u> , to <u>July 7, 1960</u> that I last saw the deceased alive on <u>5 July</u> , 19 <u>60</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Pikesville 8, Md.</u> <u>July 9, 1960</u>			
ACTUAL SIGNATURE <u>Paul H Royse</u>		M.D. <u>508 R 1403 Foley Lane</u>	
PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>		<u>Pikesville 8, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	22b. DATE THEREOF <u>July 11, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Howell</u>		24a. REC'D BY REGISTRAR <u>Jul 12 '60</u>	
ADDRESS <u>Pikesville 8, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Howell</u>	

1882

CERTIFICATE OF DEATH

WEST

1

[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, date, and location.]

<div style="display: flex; justify-content: space-between;"> 1 7722 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 07689 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;"> CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>306 N. ROLLING RD.</u>					d. STREET ADDRESS <u>1306 N. ROLLING RD.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ADELA</u>		First <u>LOUISE</u> Middle <u>DEFORD</u> Last		4. DATE OF DEATH Month <u>JULY</u> Day <u>13</u> Year <u>1960</u>					
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 14, 1879</u>		9. AGE (In years last birthday) <u>80</u> yrs.	
				IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY KEIDEL</u>					14. MOTHER'S MAIDEN NAME <u>ADELA LAWRENCE</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MR. LOUIS DEFORD, 306 N. ROLLING RD.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1954</u> to <u>July 13, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 13, 1960</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>D.C. MacLaughlin</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>D.C. MacLaughlin, M. D.</u>					22d. ADDRESS <u>4508 Edmondson Village</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>7/15/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE FUN. DIR. 4101 EDMONDSON AVE.</u>					25a. REC'D BY REGISTRAR DATE <u>JUL 15 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		

MEDICAL CERTIFICATION

03069

CERTIFICATE OF DEATH

1951 1121



NAME OF DECEASED
APRIL 1951
PLACE OF BIRTH
DATE OF BIRTH
SEX
RACE
EDUCATION
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
SIGNATURE OF REGISTRAR
OFFICIAL SEAL

MADE IN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7723

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07690

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 16 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle J Last De POITIERS		4. DATE OF DEATH Month JULY Day 6 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 30 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY PLUMBING CO	
11. BIRTHPLACE (State or foreign country) BALTO MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME GUSTAVE DePOITIERS		14. MOTHER'S MAIDEN NAME WALLY BESSER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 216-10-9755	
17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: EDEMA OF LUNGS IMMEDIATE CAUSE (a) CARDIAC HYPERTROPHY AND DILATATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DIABETES MELLITUS MARKED GENERALIZED ARTERIOSCLEROSIS (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 Day UNK UNK UNK			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Status post surgical amputation both legs for arteriosclerotic obliterans			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 20 19 60 to JULY 6 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7/6/60 19 60 , and that death occurred at 2:35 PM on the causes and on the date stated above.			
22a. SIGNATURE Thomas R. Hood		22b. DATE SIGNED 7/7/60	
22c. PHYSICIAN'S NAME (Type) THOMAS R HOOD		22d. ADDRESS VAH BALTO 18 MD FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-11-60	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.		25a. REC'D BY REGISTRAR DATE JUL 12 '60	
ADDRESS 6009 Harford Road		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7724

CERTIFICATE OF DEATH

07692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home		d. STREET ADDRESS 2312 N. Charles Street	
3. NAME OF DECEASED (Type or print) First MAUDE Middle E. Last DRYDEN		4. DATE OF DEATH Month July Day 30 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1876
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) White Hall, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Elliott		14. MOTHER'S MAIDEN NAME Sallie Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Thomas E. Dryden-2312 N. Charles Street #18		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of hip (right) 6/2/60			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 19 60 to July 30, 19 60 , that I last saw the deceased alive on July 30, 19 60 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE F.M. TUGAN		DATE SIGNED 15 E BIDDLEST BALTIMORE MD	
PHYSICIAN'S NAME (Type) F.M. TUGAN MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/2/60	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery	22d. LOCATION (City, town, or county) (State) Pikesville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tuckman		24a. REC'D BY REGISTRAR DATE AUG 3 '60	
ADDRESS Beth - 17, Md.		24b. REGISTRAR'S SIGNATURE William S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 10/57

Key-Charles F. Brownel MD Baltimore

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Time of Death		Place of Death		Cause of Death	
John Doe		45		Male		White		1912		10:30 AM		Home		Heart Disease	
Occupation		Residence		Marital Status		Previous Illnesses		Last Medical Examination		Manner of Death		Burial Place		Burial Date	
Teacher		123 Main St.		Married		None		1911		Natural		Cemetery		1912	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family		Signature of Minister		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1234567890

1234567890

1234567890

7689

MEDICAL CERTIFICATION

VS. A15ME(S)
SM 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

7725

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07693

1. PLACE OF DEATH a. COUNTY Balto. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 201 N. Beechwood Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville d. STREET ADDRESS 201 N. Beechwood Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle MILTON Last EARECKSON, P.V.		4. DATE OF DEATH Month July Day 11 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman		10b. KIND OF BUSINESS OR INDUSTRY Bishop Cummins' R. E. Church	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Milton Eareckson, Sr.		14. MOTHER'S MAIDEN NAME Anna M. Cacy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. L. Ruth Eareckson - 201 N. Beechwood Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma of sigmoid colon DUE TO (b) metastases Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1952 to July 11, 1960 , that (I) (we) last saw the deceased alive on 7/9/60 , and that death occurred at 4:30 P. M. from the causes and on the date stated above.			
22a. SIGNATURE LESTER A. WALLACE		22b. DATE SIGNED 7/12/60	
22c. PHYSICIAN'S NAME (Type) LESTER A. WALLACE		22d. ADDRESS 1039 St Paul St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/14/60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City, town, or county) (State) Balto., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto 17th		25a. REC'D BY REGISTRAR JUL 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

81828

CERTIFICATE OF DEATH

7757



ADDITIONAL INFORMATION

ADDITIONAL INFORMATION

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
9
7726
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07694

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN lb 189 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1450 LANGFORD ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle R. Last EIDEMILLER		4. DATE OF DEATH Month JULY Day 1 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 24, 1898
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR: Months 62 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Construction Analyst Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Eidemiller		14. MOTHER'S MAIDEN NAME Louise Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 213 28 1167	
17. INFORMANT Clinical Rec. VAH, Balto 18, Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 522X IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: OLD CEREBRAL INFARCTION RIGHT 3022X (b) MARKED GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from December 14, 1959 to July 1, 1960 , that (x) (we) last saw the deceased alive on July 1, 1960 , and that death occurred at 1:50pm from the causes and on the date stated above.			
22a. SIGNATURE Charles Allen		22b. DATE SIGNED 7/1/60	
22c. PHYSICIAN'S NAME (Type) CHARLES ALLEN, M.D.		22d. ADDRESS VAH, BALTO. MD. - FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF July 4/60	
23c. NAME OF CEMETERY OR CREMATORY Allegheny Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Pittsburgh, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Witke Funeral Dir.		25a. REC'D BY REGISTRAR JUL 5 '60	
ADDRESS 1401 Edmondson Ave. Balto. Md.		25b. REGISTRAR'S SIGNATURE Arthur L. House	

11450

11450

11450

11450

11450

11450

11450

11450

11450

11450

11450

11450

11450

11450

11450

11450

11450

11450

11450

11450

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7679

CERTIFICATE OF DEATH

Reg. Dist. No.

07695

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Kent</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. LENGTH OF STAY IN 1b <u>1 1/2 Months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Owen</u> Last <u>Elbourn</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/21/1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>21</u> Days <u>21</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>							
13. FATHER'S NAME <u>Joseph Leonard Elbourn</u>				14. MOTHER'S MAIDEN NAME <u>Harriot Beck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>218-16-6481</u>		17. INFORMANT <u>MYRA THARP (Daughter)</u> Address <u>BALTO. MD. 4801 ELDON GREEN</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> DUE TO <u>162.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 23, 1960</u> , to <u>July 21, 1960</u> , that I last saw the deceased alive on <u>July 21, 1960</u> , and that death occurred at <u>11 p. m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3322 FREDERICK AV. BALTO. MD.</u> DATE SIGNED <u>7/22/60</u>							
ACTUAL SIGNATURE <u>Abram Goldman, M.D.</u>				PHYSICIAN'S NAME (Type) <u>ABRAM GOLDMAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>7-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	
22d. LOCATION (City, town, or county) (State) <u>Rock Hall MD</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill</u>		24a. REC'D BY REGISTRAR <u>JUL 26 60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>							

CERTIFICATE OF DEATH

1978

DEATH OF NAME OF DECEASED		SEX MALE <input checked="" type="checkbox"/> FEMALE <input type="checkbox"/>	
DATE OF DEATH MONTH DAY YEAR		PLACE OF DEATH HOME <input type="checkbox"/> HOSPITAL <input type="checkbox"/> NURSING HOME <input type="checkbox"/> OTHER <input type="checkbox"/>	
AGE YEARS MONTHS DAYS		OCCUPATION NAME OF EMPLOYER	
CAUSE OF DEATH IMMEDIATE CAUSE		UNDERLYING CAUSE	
MANNER OF DEATH NATURAL <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> UNDETERMINED <input type="checkbox"/>		SIGNATURE OF PHYSICIAN NAME OF PHYSICIAN	
SIGNATURE OF REGISTRAR NAME OF REGISTRAR		DATE OF REGISTRATION	

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH - BALTIMORE
 AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED
 AT THE TIME OF DEATH.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07696

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN lb 14 yrs		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		d. STREET ADDRESS 2 Tanglewood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KENNETH EVANS		4. DATE OF DEATH Month July Day 6 Year 19 60		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-14-16		9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		10b. KIND OF BUSINESS OR INDUSTRY FOUNTAIN SYRUP		11. BIRTHPLACE (State or foreign country) WALES		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM EVANS		14. MOTHER'S MAIDEN NAME MARY ANNE DYKE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WWII		16. SOCIAL SECURITY NO. 14-03-5466		17. INFORMANT ELLEN EVANS 2 TANGLEWOOD RD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														7/7/60			
ACTUAL SIGNATURE <i>Wm. V. Lovitt</i>		EXAMINER'S NAME (Type) Wm. V. Lovitt, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-11-60		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM		22d. LOCATION (City, town, or country) BALTO MD		(County)		(State)		23. FUNERAL DIRECTOR C. F. EVANS & SON		24a. REC'D BY REGISTRAR JUL 11 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kiana</i>	

07898

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

11/10/1910

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7728

07697

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 55 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 829 Patapsco Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HENRY Middle M. Last FAGAN		4. DATE OF DEATH Month JULY Day 4 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1899	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Fagan				14. MOTHER'S MAIDEN NAME Rebecca Jane Hainsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 209-01-5266		17. INFORMANT Clin. Records, Vet. Adm Hosp Balto. Md. Ft. Howard Div			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EDEMA OF THE LUNGS 522X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2. CARCINOMA OF THE PROSTATE WITH METASTASIS TO BONE, LIVER AND RIGHT LUNG (c) 1 1/2 YEARS		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. May Day. 10 Year. 1960 Hour o. m. 10:15 AM p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 829 Patapsco Ave		20f. (City or town) (County) (State) BALTO. MD. FT HOWARD DIV	
21. I certify that PHILIP J. JENSEN (this hospital) attended the deceased from May 10, 1960 to July 4, 1960 (we) last saw the deceased alive on July 4, 1960 , and that death occurred at 10:15 AM the causes and on the date stated above.							
22a. SIGNATURE Philip J. Jensen		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/4/60			
22c. PHYSICIAN'S NAME (Type) PHILIP J. JENSEN, M.D.		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7-6-60		23c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery		23d. LOCATION (City, town, or county) (State) Altoona, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE Wm-Cook Blight Inc. 6009 Harford Rd. Balto Md				25a. REC'D BY REGISTRAR DATE JUL 8 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

Male

STATE OF TEXAS
COUNTY OF DALLAS

1934

1

1

Blank document with faint horizontal lines and circular stamps.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7729

CERTIFICATE OF DEATH

Reg. Dist. No. 07698

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res. Eastern Ave. & Birdwood Rds.				d. STREET ADDRESS Box 50 Rt 14, 20, Md.			
3. NAME OF DECEASED (Type or print) First Carrie Middle R. Last Fickus				4. DATE OF DEATH Month July Day 28 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1876	9. AGE (In years and birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Koester			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) No (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Julia Debelius Eastern & Birdwood Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Stomach c Metastases 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubid Ulcers						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from June , 19 50 , to July 28 , 19 60 , that I last saw the deceased alive on July 27 , 19 60 , and that death occurred at 6 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert J. Lyden		M.D. B. J. S. Eastern Ave		ADDRESS (Street, city or town, state) Balt 21, Md		DATE SIGNED 7/29/60	
PHYSICIAN'S NAME (Type) ROBERT J. LYDEN (M.D.)							
22a. BURIAL, CREMATION, RE interment (Specify) Burial	22b. DATE THEREOF 8-1-1960	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Ave. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 7922 Wise Ave. 22, Md.			24a. REC'D BY REGISTRAR DATE AUG 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

CERTIFICATE OF DEATH

1153

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1898		BALTIMORE, MD.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
LABORER		HIGH SCHOOL		MARRIED		METHODIST		WHITE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
JAN 20 1945		BALTIMORE, MD.		HEART DISEASE		NATURAL		1153	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		DATE		DATE		DATE		DATE	
JAN 20 1945		JAN 20 1945		JAN 20 1945		JAN 20 1945		JAN 20 1945	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH—BALTIMORE, 18

Item 6 Film G267 7/14/60 iwk

07699

7687

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9901 HARFORD RD</u>		d. STREET ADDRESS <u>1 9901 HARFORD RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ANN</u> Last <u>FINNEY</u>		4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1867</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John V Keeney</u>		14. MOTHER'S MAIDEN NAME <u>SARAL C MILLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ADA N Cleveland</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>associated secondary anemia</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular disease; malnutrition</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. INCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If other, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>47</u> to <u>July 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 3</u> , 19 <u>60</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>H. V. Harbold</u> M.D. <u>4706 Harford Road</u>		<u>7/6/60</u>	
PHYSICIAN'S NAME (Type) <u>H. V. HARBOLD M.D. Baltimore-14, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-8-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD LEM.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS & SON</u> ADDRESS <u>8802 NORTON RD</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 11 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7730

CERTIFICATE OF DEATH

Reg. Dist. No. 07700

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Ellicott City				c. LENGTH OF STAY IN 1b 65 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION River Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCIS Middle JOSEPH Last FISHER				4. DATE OF DEATH Month July Day 4th. Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 14, 1894	
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frank A. Fisher				14. MOTHER'S MAIDEN NAME Mary M. Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-34-3025			
17. INFORMANT Mrs. Mary E. Fisher				Address River Rd. Ellicott City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Fundus of Stomach DUE TO (b) 151X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) 8 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 0				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 12-1 , 19 59 , to 7-4 , 19 60 , that I lost sowed the deceased olive on 7-4 , 19 60 , and that death occurred at 1:40 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE George E. Burtorf				ADDRESS (Street, city or town, state) 41 CHURCH ST DATE SIGNED 7-6-60			
PHYSICIAN'S NAME (Type) GEORGE E. BURTORF				M.D. ELlicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7, 1960		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Ilchester, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sons				ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR DATE JUL 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

CERTIFICATE OF DEATH

<p>1. Name of deceased (Print name and surname) _____</p>		<p>2. Sex _____</p>		<p>3. Date of birth _____</p>	
<p>4. Usual residence _____</p>		<p>5. Date of death _____</p>		<p>6. Cause of death (Print full name of disease or injury) _____</p>	
<p>7. Signature of Registrar _____</p>		<p>8. Signature of Medical Officer _____</p>		<p>9. Signature of Coroner _____</p>	
<p>10. Date of registration _____</p>		<p>11. Place of registration _____</p>		<p>12. District _____</p>	

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7731

CERTIFICATE OF DEATH

07701
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6534 CORKLEY AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES RICHARD FISHER SR.				4. DATE OF DEATH Month Day Year JULY 26 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV 14, 1911	
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DELIVERY MAN				10b. KIND OF BUSINESS OR INDUSTRY HUTZLERS		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME William Fisher				14. MOTHER'S MAIDEN NAME Rose Marie Diggins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-07-2672			
17. INFORMANT Dorothy Fisher				Address 6534 Corkley Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lacmuc's Chronic Cirrhosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 2 , 19 60 to July 26 , 19 60 , that I last saw the deceased alive on July 26 , 19 60 , and that death occurred at 2:00 PM , from the causes and on the date stated above. DATE SIGNED John L. Smith, M.D. ADDRESS (Street, city or town, state) 8019 Philadelphia Road							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF JUL 29, 1960		22c. NAME OF CEMETERY OR CREMATORY HOLT REDEEMER	
22d. LOCATION (City, town, or county) (State) BALTO, CITY MD.				23. FUNERAL DIRECTOR'S SIGNATURE Sossahn Funeral Home			
ADDRESS 7401 Belair Rd #6				24a. REC'D BY REGISTRAR DATE JUL 27 '60		24b. REGISTRAR'S SIGNATURE Arthur J. Smith	

0550

CERTIFICATE OF WORK

1131



[Faint, mostly illegible text covering the majority of the page, likely bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> SV01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fisher Road</u>				d. STREET ADDRESS <u>4303 Glenmore Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Mr. Bayard Taylor Fleming</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18th</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1885</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Parker Metal Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>New Castle, Delaware</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>215-07-0155</u>		17. INFORMANT <u>Mrs. Isabelle B. Fleming</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>JACK E. COLLINS</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-18-60</u>			
EXAMINER'S NAME (Type) <u>JACK E. COLLINS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 21 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any fee is necessary, please enclose it with this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7732

CERTIFICATE OF DEATH

07703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 8yr 4mth 28dys		d. STREET ADDRESS 3378 North Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Edward Middle Anthony Last Foley		4. DATE OF DEATH Month July Day 5 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1912
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 4 Days 19 Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Patrick G. Foley		14. MOTHER'S MAIDEN NAME Katherine Schrota	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 110th fld art. 1934?		16. SOCIAL SECURITY NO. 213-05-5060	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **Feb. 7, 19 52** to **July 5, 19 60**, that I last saw the deceased alive on **July 5, 19 60**, and that death occurred at **6:30 a.m.** from the causes and on the date stated above.

ACTUAL SIGNATURE **Stella Wachslar** ADDRESS (Street, city or town, state) **SPRING GROVE STATE HOSPITAL** DATE SIGNED **7-5-60**
PHYSICIAN'S NAME (Type) **Stella Wachslar, M. D.** **Catonsville 28, Maryland**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/14/60	22c. NAME OF CEMETERY OR CREMATORY Catharine	22d. LOCATION (City, town, or county) (State) 4300 Old Federal Rd
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Foley		24a. REC'D BY REGISTRAR Date JUL 18 1960	24b. REGISTRAR'S SIGNATURE Charles L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Use Blue Ink

DECEASED NAME JAMES H. HARRIS		SEX Male	
AGE 65		DATE OF BIRTH Jan 15, 1880	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Married		DATE OF MARRIAGE Dec 10, 1905	
NAME OF SPOUSE Mary E. Harris		PLACE OF MARRIAGE Baltimore, Md.	
CAUSE OF DEATH Myocardial Infarction		PLACE OF DEATH Home	
DATE OF DEATH Jan 10, 1945		TIME OF DEATH 11:00 AM	
PLACE OF DEATH 1234 Elm St., Baltimore, Md.		COUNTY Baltimore	
CITY Baltimore		STATE Maryland	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CLERK (None)	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4300 Wilkens Ave</u>		d. STREET ADDRESS <u>14200 Wilkens Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Eleanor</u> First Middle Last		4. DATE OF DEATH <u>July</u> Month <u>17</u> Day <u>1960</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk Emerson Herig</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>W.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>W.S.A.</u>	
13. FATHER'S NAME <u>F.W. Fox</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Watkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>216-05-0194</u>	
17. INFORMANT <u>Mrs. David Updegraff</u> Address <u>4200 Wilkens Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Edema of lungs</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ch. Valvular heart disease</u> DUE TO (c) <u>Arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>3 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>July 17, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 17, 1960</u> , and that death occurred on <u>July 17, 1960</u> at <u>8:57 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Geo. E. Wells</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Geo. E. Wells</u>		22d. ADDRESS <u>4100 Edmondson Ave. - Balto 29</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>7/20/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Pk</u>		23d. LOCATION (City, town, or county) <u>Balto. 7, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wittke F.W.</u>		25a. REC'D BY REGISTRAR <u>Jul 21 60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7733

CERTIFICATE OF DEATH

Reg. Dist. No. 07705

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt 16 Box 49 Balto, 20</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>N.</u> Last <u>Frank</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-5-1898</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housew. fr</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hanford Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Benjamin Cadle</u>				14. MOTHER'S MAIDEN NAME <u>Alice Strong.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-01-0752</u>			
17. INFORMANT Address <u>Walter R Frank Rt 16 Box 49 Balto 20.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Anterosclerosis, Generalized -</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>ASHD + Cerebral Arteriosclerosis</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>July 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 25</u> , 19 <u>60</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert J. Lyden</u>				DATE SIGNED <u>515 Eastern Ave (Balt 2), md 7/26/60</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-29-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Belair Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Family Home 7401 Belair Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1893

(M)

(1)

IN SENATE
JANUARY 12, 1894
REPORT OF THE
COMMISSIONER OF HEALTH
ON THE
VITAL RECORDS OF THE STATE OF NEW YORK
FOR THE YEAR 1893
ALBANY: J. B. LIPPINCOTT & CO. PRINTERS
1894

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7734

07706

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mth8days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 606 Brookwood Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louisa M. Frieese		4. DATE OF DEATH Month July Day 23 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1877, July 3, 83
9. AGE (In years last birthday) 22		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 20 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 13, 1960 to July 23, 1960 . that (I) (we) last saw the deceased alive on July 23, 1960 , and that death occurred at 11A AM, from the causes and on the date stated above.			
22a. SIGNATURE Loretta Y. F. Hsu		22b. DATE SIGNED July 23, 1960	
22c. PHYSICIAN'S NAME (Type) LORETTA Y. F. HSU		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/26/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE JUL 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

12704

CERTIFICATE OF DEATH

1184

11

M

1

Baltimore, Md.

WILLIAM F. DILL, M.D., M.D.

7/26/50

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7688

CERTIFICATE OF DEATH

Reg. Dist. No. 07207

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3207 E. Joppa Road</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i> d. STREET ADDRESS <i>3207 E. Joppa Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Rosie</i> Middle <i>Lee</i> Last <i>Fuller</i>				4. DATE OF DEATH Month <i>July</i> Day <i>4</i> Year <i>19 60</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-16-1875</i>	
9. AGE (In years lost birthday) <i>84</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Henry Penn Dent</i>				14. MOTHER'S MAIDEN NAME <i>Amanda Shanklin</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <i>Howard Fuller</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Degenerate heart disease</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>old age.</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 3, 1960</i> , to <i>July 4, 1960</i> , that I last saw the deceased alive on <i>July 3, 1960</i> , and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Harold H. Burns</i> M.D.				ADDRESS (Street, city or town, state) <i>8106 Harford Rd. Baltimore, Md.</i>			
PHYSICIAN'S NAME (Type) <i>Harold - H. Burns.</i>				DATE SIGNED <i>7-6-60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>7/7/1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hiss Methodist Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR <i>DATE JUL 11 '60</i>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1888

1888

(M)

(1)

Blank form with horizontal lines for text entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
7735					07708				
1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b <u>60 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5806 EDMONDSON AVE</u>					d. STREET ADDRESS <u>1 5806 EDMONDSON AVE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROSA E. GANTT</u>					4. DATE OF DEATH Month Day Year <u>JULY 13 1960</u>				
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 25, 1894</u>		9. AGE (In years last birthday) <u>86</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>THOMAS JUSTICE</u>					14. MOTHER'S MAIDEN NAME <u>SARAH RICHARD</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinomatosis</u> DUE TO <u>Carcinoma of stomach</u> (c) <u>1 yr?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 days.</u> <u>6 mos.</u> <u>1 yr?</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>July 13, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 13, 1960</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Geo. E. Wells.</u>					22b. DATE SIGNED <u>July 13, 1960</u>				
22c. PHYSICIAN'S NAME (Type) <u>GEO. E. WELLS.</u>					22d. ADDRESS <u>4100 Edmondson Ave. Balto.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>7/16/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK</u>		23d. LOCATION (City, town, or county) <u>BALTO. MD.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUN. DIR, 4101 EDMONDSON AVE</u>					25a. REC'D BY REGISTRAR DATE <u>JUL 18 60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Pruss</u>		

1933

11

Baltimore

White

Male

1905

1100

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 10/57

1
7736
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

07709

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PARKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3077 BALDER HUE</u>		d. STREET ADDRESS <u>13077 BALDER HUE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELLEN</u> Middle <u>C</u> Last <u>GASKINS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 1, 1880</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HL HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS WHEELEY</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN OWENS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FAMILY RECORDS</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO <u>congestive failure grade IV</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 15, 1960</u> to <u>July 15, 1960</u> that I last saw the deceased alive on <u>July 15, 1960</u> and that death occurred at <u>8:30 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald W. Mintz</u> M.D.		ADDRESS (Street, city or town, state) <u>3509 Eversgreen Ave</u> DATE SIGNED <u>7/18/60</u>	
PHYSICIAN'S NAME (Type) <u>DONALD W. MINTZ</u>		<u>Baltimore MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-19-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NOBEL HANDBENNA PR</u>		22d. LOCATION (City, town, or county) <u>BALTO Co</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS</u> ADDRESS <u>1 SON 8802 Warford Rd</u>		24a. REC'D BY REGISTRAR <u>JUL 19 60</u> DATE <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

100

7737

CERTIFICATE OF DEATH

07710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 137 Sipple Ave				d. STREET ADDRESS 137 Sipple Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First August Middle Gemeinhardt Last				4. DATE OF DEATH Month July Day 10 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 3, 1892	
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker				10b. KIND OF BUSINESS OR INDUSTRY Transit			
13. FATHER'S NAME John Gemeinhardt				14. MOTHER'S MAIDEN NAME Hanna Stoecker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W. W. # 2 213-10-1004			
17. INFORMANT Mrs. Geraldine Duke				Address 137 Sipple Ave. 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Pulmonary Tuberculosis, heart & aorta							INTERVAL BETWEEN ONSET AND DEATH 5 months 4 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 Feb , 19 57 , to 10 July , 19 60 , that I last saw the deceased alive on 9 July , 19 60 , and that death occurred at 1011 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard Goodman		ADDRESS (Street, city or town, state) 8604 Harford Rd Baltimore, Md.					
PHYSICIAN'S NAME (Type) Howard Goodman		DATE SIGNED Baltimore, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-1960		22c. NAME OF CEMETERY OR CREMATORY Balto. U.S. National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR DATE JUL 15 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. K...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF ARIZONA
CERTIFICATE OF DEATH

1933

(A)

(1)

1. Name of deceased: _____

2. Sex: _____

3. Date of birth: _____

4. Place of birth: _____

5. Cause of death: _____

6. Date of death: _____

7. Place of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Signature of informant: _____

11. Signature of medical examiner: _____

12. Signature of coroner: _____

13. Signature of funeral director: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1

7738

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07711

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUMMIT NURSING HOME</u>				e. STREET ADDRESS <u>2350 RESEARCH AVE</u>			
3. NAME OF DECEASED (Type or print) <u>HENRY FREDERICK GLENSKY</u>				4. DATE OF DEATH <u>JULY 27 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 18 1881</u>	
9. AGE (In years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>			
13. FATHER'S NAME <u>ROBERT GLENSKY</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-03-0445</u>		17. INFORMANT <u>WALTER GLENSKY</u> Address <u>1102 ELM RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Arteriosclerotic CVD, generalized</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 1959</u> to <u>July 26 1960</u> , that (I) (we) last saw the deceased alive on <u>July 26 1960</u> , and that death occurred <u>over</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Herbert J. Levickas</u>				22b. DATE SIGNED <u>7/28/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>				22d. ADDRESS <u>5305 East Drive</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-30-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GOVANSTOWN PRESBYTERIAN</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>EEO. L. Schomburg</u>				25a. REC'D BY REGISTRAR <u>AUG 1 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

7681

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07712

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. LENGTH OF STAY IN 1b 57	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2616 Braun Avenue		d. STREET ADDRESS 2616 Braun Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Katherine Middle T. Last Goeller		4. DATE OF DEATH Month July Day 24 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1892
9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Otten		14. MOTHER'S MAIDEN NAME Julia M. Born	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT John D. Goeller		Address 2616 Braun Ave. Lansdowne Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 MOS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 26 1947 to July 24 1960 , that (I) (we) last saw the deceased alive on July 22 1960 , and that death occurred at 5 PM , from the causes and on the date stated above.			
22a. SIGNATURE C. Arthur Rossberg Md.		22b. DATE SIGNED 7/25/60	
22c. PHYSICIAN'S NAME (Type) C. Arthur Rossberg		22d. ADDRESS 2436 Washington Blvd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/60	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave.	
25a. REC'D BY REGISTRAR JUL 27 '60		25b. REGISTRAR'S SIGNATURE Carlton S. Frank	

3004



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7739

07713

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Chase)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Rural (Chase)</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs.</u>				d. STREET ADDRESS <u>Bx 466 B. Carroll Island Rd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>H.</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 14 - 1898</u>	
9. AGE (in years lost birthday) <u>61</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>motion picture operator</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George Green</u>				14. MOTHER'S MAIDEN NAME <u>Cluffy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>213-05-8053</u>		17. INFORMANT <u>Gordon V. Green</u> Address <u>(above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Febr. 23, 1960</u> to <u>July 15, 1960</u> that (I) (we) last saw the deceased alive on <u>July 14, 1960</u> , and that death occurred at <u>5:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Leopoldo Gruss</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Leopoldo Gruss M.D.</u>				22d. ADDRESS <u>405 Stemmers Run Rd, Balto 21</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-19-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u>				25a. REC'D BY REGISTRAR <u>418 Eastern Blvd</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

(M)

(1)

(0)

(1)

(Bp)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

7740 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07714

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 13 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 320 BIRCHWOOD PLACE	
3. NAME OF DECEASED (Type or print) First GEORGE Middle CONRAD Last GUNZELMAN		4. DATE OF DEATH Month JULY Day 10 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 2, 1889
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOOKKEEPER		10b. KIND OF BUSINESS OR INDUSTRY PACKING HOUSE	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE C. GUNZELMAN		14. MOTHER'S MAIDEN NAME MARGARET DIETZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-12-4534	
17. INFORMANT Clinrec VAH, Balto Md. Ft. Howard Div.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA, PNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH 10 DAYS UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from June 27, 1960 to July 10, 1960 , that (we) lost the deceased alive on July 10, 1960 , and that death occurred at 11:15 PM from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter J. Pijanowski</i> WALTER J. PIJANOWSKI, M.D.		22b. DATE SIGNED 7/11/60	
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.		22d. ADDRESS VAH, BALTIMORE, MD. - FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tickner Funeral Home, Pa & North Ave. Balto. Md.		25a. REC'D BY REGISTRAR DATE JUL 12 '60	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7741

CERTIFICATE OF DEATH

07715

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex #21				c. LENGTH OF STAY IN 1b 54 Essex #21			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lasky Ave. Cape May Beach				d. STREET ADDRESS 1016 Essex Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First EMMA Middle AUGUSTA Last HALL				4. DATE OF DEATH Month July Day 26 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13, 1875	
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank Godwin				14. MOTHER'S MAIDEN NAME Martha Ross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ethel Leary		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure DUE TO Intraabdominal abscess Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cholecystitis (Cholecystectomy) (c) Hypertensive cardiovascular disease, arteriosclerotic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease, arteriosclerotic							
INTERVAL BETWEEN ONSET AND DEATH 1 day 19 days 23 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 15, 1960 , to July 26, 1960 , that I last saw the deceased alive on July 25, 1960 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Eugene C. Baumann				ADDRESS (Street, city or town, state) 413 Eastern Ave., Essex 21, Md			
DATE SIGNED 7-27-60							
PHYSICIAN'S NAME (Type) Eugene C. Baumann							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/30/60		22c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery		22d. LOCATION (City, town, or county) (State) Queen Anne County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James Bruzdinski 1407 Eastern Ave.				24a. REC'D BY REGISTRAR JUL 29 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

10371

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

TRAUMA

POISONING

OTHER

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

INTERMEDIATE CAUSE

UNDERLYING CAUSE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

7742

7742

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07716

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN 1b 38 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS d. STREET ADDRESS 3 COLLEGE CREEK TERRACE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NICHOLAS Middle ---- Last HAMILTON		4. DATE OF DEATH Month JULY Day 25 Year 1960	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 3, 1893
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVAL ACADEMY	
11. BIRTHPLACE (State or foreign country) ANNAPOLIS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HAMILTON		14. MOTHER'S MAIDEN NAME HESTER STEWART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 214-05-2489	
17. INFORMANT CLIN.REC.VAH FT HOWARD DIV. BALTO 18,MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MARKED HYPERTROPHY & DILATATION OF HEART 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) ANASARCA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Edema of the lungs; abscesses of prostate		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 1 month	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 17 1960 to July 25 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 25 1960 , and that death occurred at 9:10AM from the causes and on the date stated above.			
22a. SIGNATURE Walter J. Pijanowski		22b. DATE SIGNED 7/25/60	
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.		22d. ADDRESS VAH FT HOWARD DIV. BALTO MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-29-60	
23c. NAME OF CEMETERY OR CREMATORY MT MORIAH Anna. Natl.		23d. LOCATION (City, town, or county) (State) ANNAPOLIS, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Wm Reese, Washington St, Annapolis, Md		25a. REC'D BY REGISTRAR JUL 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

54

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7743

07717

Item 23b, Film 0267 7/27/60

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>54 Middle River</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ap. 15 Box 183 Balto. 20</i>				d. STREET ADDRESS <i>Ap. 15 Box 183 Balto. 20</i>			
3. NAME OF DECEASED (Type or print) <i>EVA W HAMMOND</i>				4. DATE OF DEATH Month <i>JULY</i> Day <i>19</i> Year <i>1960</i>			
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 7, 1886</i>	9. AGE (In years last birthday) <i>74</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maine</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>L. L. Winslow</i>				14. MOTHER'S MAIDEN NAME <i>Estelle Perkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Flourno Senesch</i> Address <i>(Same as above)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac Decompensation</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio-sclerotic Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>3 1/2 yrs</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 28, 1959</i> to <i>July 19, 1960</i> , that (I) (we) last saw the deceased alive on <i>May 16, 1960</i> , and that death occurred on <i>July 19, 1960</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Joseph Miceli</i>				22b. DATE SIGNED <i>7/20/60</i>		22c. PHYSICIAN'S NAME (Type) <i>JOSEPH MICELI M.D.</i>	
22d. ADDRESS <i>108 S. TAYLOR AVE BALTO. 21, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE THEREOF <i>July 21, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>RIVERSIDE ANNEX</i>		23d. LOCATION (City, town, or county) (State) <i>SOUTH PARIS MAINE</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connelly</i>				25a. REC'D BY REGISTRAR <i>418 Eastern Blvd Balto. 21</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

11711

CERTIFICATE OF DEATH

11711

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]



[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

CERTIFICATE OF DEATH

Reg. Dist. No. **07718**

7744

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 812 Regester Avenue		d. STREET ADDRESS 16510 Loch Hill Court	
3. NAME OF DECEASED (Type or print) Mrs. Blanche Olivia Hargett		4. DATE OF DEATH July 11th 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1882
9. AGE (In years lost birthday) 77 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alphonso Claggett		14. MOTHER'S MAIDEN NAME Molly V. Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-01-9594	
17. INFORMANT Mr. Arthur M. Hargett, 6510 Loch Hill Ct.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe urinary tract infection (c) Severe epidemic neurosyphilis and degeneration of the spine - cause undetermined		INTERVAL BETWEEN ONSET AND DEATH immediate 10 days 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiac-vascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March, 1954 , to 11 July 1960 that I last saw the deceased alive on 10 July 1960 , and that death occurred at 10:27 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Douglas Lockard		DATE SIGNED 11 July 1960	
PHYSICIAN'S NAME (Type) Baltimore - 1, Md.		M.D. 802 Cathedral Street	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/14/60	22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR JUL 14 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

04822-19-519

92615

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7745

07719

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto. Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines - Fusting Ave.				d. STREET ADDRESS The Marylander Apts.			
3. NAME OF DECEASED (Type or print) First BLANCHE Middle W. Last HARRIS				4. DATE OF DEATH Month July Day 5 Year 19 60			
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1885	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? Virginia	
13. FATHER'S NAME Albert F. Shackelford				14. MOTHER'S MAIDEN NAME Mary Catherine Wallace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Maude S. Powell - 307 Southway - Balto. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia - Chr. nephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio sclerosis. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Balto.		(County) MD.		(State) MD.
21. I certify that (I) (this hospital) attended the deceased from Jan 19 19 60 to July 5 19 60 , that (I) (we) last saw the deceased alive on July 4 19 60 , and that death occurred at 8 A. M., from the causes and on the date stated above.							
22a. SIGNATURE D. BERNARD J. COHEN				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) D. BERNARD J. COHEN				22d. ADDRESS The Marylander apt.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/60		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Balto 17				25a. REC'D BY REGISTRAR DATE JUN 6 '60		25b. REGISTRAR'S SIGNATURE James S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1111

CENTRAL AIR FORCE

1111



1111

1111

1111

1111

1111



1111

1111

1111

1111

1111

1

7746

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07720

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EARL Middle -- Last HARVEY		4. DATE OF DEATH Month JULY Day 7 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 28 1888
9. AGE (In years lost birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER	11. BIRTHPLACE (State or foreign country) LYNCHBURG, VA
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME JESSE HARVEY	
14. MOTHER'S MAIDEN NAME FANNIE STINNETT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I	
16. SOCIAL SECURITY NO. 215-10-3933		17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIV	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE WITH CARDIAC INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.0 (c) UNKNOWN DUE TO (b) UNKNOWN (c) UNKNOWN			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Adenocarcinoma of rectum. 2. Emphysema of lung due to unknown cause			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 6 19 60 to JULY 7 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on JULY 7 19 60 , and that death occurred at 10:29 A M, from the causes and on the date stated above.			
22a. SIGNATURE Thomas R. Hood		22b. DATE 7/7/60	
22c. PHYSICIAN'S NAME (Type) THOMAS R HOOD		22d. ADDRESS VAH BALTO 18 MD FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 11, 1960	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	23d. LOCATION (City, town, or county) (State) Balto. Md
24. FUNERAL DIRECTOR'S SIGNATURE Philip E. Cwach		25a. REC'D BY REGISTRAR JUL 12 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank		25c. ADDRESS 1211 Chesaco Ave. Balto. 6, Md.	

03780

CEN DEATH OF DEATH

1146

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 1c Film G267 7-14-60 et

CERTIFICATE OF DEATH

07721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P. S.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gustav Middle C. C. Last Hauser		4. DATE OF DEATH Month July Day 4 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-1882
9. AGE (In years last birthday) 77		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cartographic Engineer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hauser		14. MOTHER'S MAIDEN NAME Amelia Rommel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiac Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1959 to July 4, 1960 , that I last saw the deceased alive on July 4, 1960 , and that death occurred at 9:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 7/4/60			
ACTUAL SIGNATURE P. K. Yip		M.D. Spring Grove State Hospital	
PHYSICIAN'S NAME (Type) P. K. YIP, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/60	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Vickner & Sons - Balt		24a. REC'D BY REGISTRAR Jul 5 1960	
ADDRESS Balt		24b. REGISTRAR'S SIGNATURE Arthur S. Frame	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

7748

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07722

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 16 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAURICE Middle --- Last HENDERSON		4. DATE OF DEATH Month JULY Day 19 Year 19 60	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 4, 1890
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR		10b. KIND OF BUSINESS OR INDUSTRY TRANSPORTATION	
11. BIRTHPLACE (State or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME HENRY HENDERSON		14. MOTHER'S MAIDEN NAME ELIZA JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin Rec VAH Balto 18, Md Ft Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, RIGHT LOWER LOBE DUE TO 446X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) NEPHROSCLEROSIS, ADVANCED DUE TO (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that it (this hospital) attended the deceased from July 3, 1960 , to July 19, 1960 , that it (we) last saw the deceased alive on July 19, 1960 , and that death occurred at 2:10 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE <i>Walter J. Pijanowski</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.		22d. ADDRESS VAH FT HOWARD DIV. BALTO 18, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/22/60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S Phillips 1808 N Monroe St Balto Md		25a. REC'D BY REGISTRAR DATE JUL 26 '60	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

CENTRAL BOARD OF DEATH

1148



NAME	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	SEX	AGE	EDUCATION	RELIGION	ETHNICITY	STATUS
JOHN DOE	1920-01-01	1980-01-01	NEW YORK	NEW YORK	HEART DISEASE	MALE	60	HIGH SCHOOL	PROTESTANT	WHITE	WIDOWED
JANE DOE	1925-03-15	1985-03-15	NEW YORK	NEW YORK	STROKE	FEMALE	60	HIGH SCHOOL	CATHOLIC	WHITE	WIDOWED
JOHN DOE	1930-05-20	1990-05-20	NEW YORK	NEW YORK	HEART DISEASE	MALE	60	HIGH SCHOOL	PROTESTANT	WHITE	WIDOWED
JANE DOE	1935-07-25	1995-07-25	NEW YORK	NEW YORK	STROKE	FEMALE	60	HIGH SCHOOL	CATHOLIC	WHITE	WIDOWED

NAME	DATE OF BIRTH	DATE OF DEATH	PLACE OF BIRTH	PLACE OF DEATH	CAUSE OF DEATH	SEX	AGE	EDUCATION	RELIGION	ETHNICITY	STATUS
JOHN DOE	1940-09-10	2000-09-10	NEW YORK	NEW YORK	HEART DISEASE	MALE	60	HIGH SCHOOL	PROTESTANT	WHITE	WIDOWED
JANE DOE	1945-11-15	2005-11-15	NEW YORK	NEW YORK	STROKE	FEMALE	60	HIGH SCHOOL	CATHOLIC	WHITE	WIDOWED
JOHN DOE	1950-01-20	2010-01-20	NEW YORK	NEW YORK	HEART DISEASE	MALE	60	HIGH SCHOOL	PROTESTANT	WHITE	WIDOWED
JANE DOE	1955-03-25	2015-03-25	NEW YORK	NEW YORK	STROKE	FEMALE	60	HIGH SCHOOL	CATHOLIC	WHITE	WIDOWED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7749
CERTIFICATE OF DEATH

Reg. Dist. No.

07723

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN TB 2mth12dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle Drury Last Henneman		4. DATE OF DEATH Month July Day 5 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1915
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William H. Wolfe	
14. MOTHER'S MAIDEN NAME Sylvia Garner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	
16. SOCIAL SECURITY NO. 215 18 9078		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 22 , 19 60 , to July 5 , 19 60 , that I last saw the deceased alive on July 5 , 19 60 , and that death occurred at 5:50p M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 7-5-60			
ACTUAL SIGNATURE ARISTIDES M. SIMPOULOS		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) ARISTIDES M. SIMPOULOS		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/60	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke		ADDRESS 4101 Edmondson	
24a. REC'D BY REGISTRAR JUL 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7750

CERTIFICATE OF DEATH

07724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks				c. LENGTH OF STAY IN 1b 30 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glencoe Rd.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Edwin Hidey		4. DATE OF DEATH Month 7 Day 11 Year 1960		5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-2-1902		9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shipping clerk				10b. KIND OF BUSINESS OR INDUSTRY dept. store		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME William Hidey			
14. MOTHER'S MAIDEN NAME Margaret Smith				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) X Yes WW I			
16. SOCIAL SECURITY NO. 215-18-7243				17. INFORMANT Alice C. Hidey Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A. S. C. V. D. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 hours 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 19 52 to April , 19 60 , that I last saw the deceased alive on 7-11 , 19 60 , and that death occurred at 3:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter T. Kees				ADDRESS (Street, city or town, state) Cockeysville, Md. DATE SIGNED			
PHYSICIAN'S NAME (Type) Walter T. Kees M.D.				M.D. Cockeysville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-14-60		22c. NAME OF CEMETERY OR CREMATORY Jessop Methodist		22d. LOCATION (City, town, or county) (State) Sparks, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson4, Md.				24a. REC'D BY REGISTRAR 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Travis	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF HEALTH - BATHING

02/20/2004

Table 1. *Continued*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7682

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07725

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Relay</u>		c. LENGTH OF STAY IN 1b <u>35 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1739 Elm Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>E.</u> Last <u>Hunter</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1885</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John R. Hatfield</u>		14. MOTHER'S MAIDEN NAME <u>Fannie E. Hatfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Clayton Hunter</u>		Address <u>1739 Elm Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Angina Pectoris. Old Myocardial Infarction</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Angina Pectoris. Old Myocardial Infarction</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> 19 <u>60</u> to <u>7/7</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>7/7</u> 19 <u>60</u> , and that death occurred at <u>10:10</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>M. Frederick MD</u>		22b. DATE SIGNED <u>7/7/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>SN Frederick MD</u>		22d. ADDRESS <u>1305 Francis Ave Balto 27 MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/9/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Poplar Springs Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Mt Airy, Howard Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose, Inc 1328 Salford Springs Rd</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 12 '60</u>	
ADDRESS <u>1328 Salford Springs Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton L. Hines</u>	

1688

07787

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1888

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
JULY 1, 1887
ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.
1888.

ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.
1888.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7751
CERTIFICATE OF DEATH

Reg. Dist. No.

07726

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>IND.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHICAGO</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE IN PINES.</u>		d. STREET ADDRESS <u>3700 3rd St.</u>	
3. NAME OF DECEASED (Type or print) <u>First Thomas W. Middle (Irwin) Last</u>		4. DATE OF DEATH <u>7-9-60</u> 19 <u>19</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-77</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONCRETE</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas J.</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Family - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, metastatic, generalized</u> DUE TO (b) <u>Carcinoma, Prostate</u> DUE TO (c) <u>lying cause lost.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/7</u> , 19 <u>50</u> , to <u>7/9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-9</u> , 19 <u>60</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Reagan Berdani</u>		M.D. <u>5010 A Litchfield Ave</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>7/12/60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>7-13-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Balt.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McLuey - 130 E. Fort Ave.</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>JUL 15 '60</u>			

100

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7752

CERTIFICATE OF DEATH

Reg. Dist. No. 47727

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TIMONIUM</u>				c. LENGTH OF STAY IN 1b <u>15 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>604 Courtney Jenifer. JENIFER ROAD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DOROTHY DELIMA JACKSON</u>				4. DATE OF DEATH Month Day Year <u>JULY 11 1960</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 11, 1911</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>JOHN B. THOMAS</u>				14. MOTHER'S MAIDEN NAME <u>EVA PEARL CHENOWETH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs. Carroll Jackson JENIFER ROAD TIMONIUM</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE + CHRONIC UREMIA</u> <u>590X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>" + " Congestive heart failure</u> DUE TO (c) <u>BRIGHT'S DISEASE (acute + chronic glomerulonephritis)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>32 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>DECEMBER</u> , 19 <u>59</u> , to <u>JULY 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JULY 8</u> , 19 <u>60</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry L. McCorkle</u> M.D.				ADDRESS (Street, city or town, state) <u>JARRETTSVILLE PIKE</u>			
PHYSICIAN'S NAME (Type) <u>Henry L. McCorkle MD</u>				DATE SIGNED <u>7/11/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-14-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MAYS CHAPEL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>TIMONIUM MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Leno</u>				ADDRESS <u>Jawson, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7732

MARYLAND STATE DEPARTMENT OF HEALTH—BUREAU OF VITAL RECORDS

1. NAME OF DECEASED <u>JOHN J. HARRIS</u>		2. SEX <u>Male</u>		3. AGE <u>45</u>	
4. DATE OF DEATH <u>Jan 15 1910</u>		5. TIME OF DEATH <u>10:30 AM</u>		6. PLACE OF DEATH <u>Home</u>	
7. CAUSE OF DEATH <u>Heart Disease</u>		8. DISEASE OR INJURY <u>Myocarditis</u>		9. MODE OF DEATH <u>Natural</u>	
10. OCCASION OF DEATH <u>While at work</u>		11. PLACE OF BIRTH <u>MD</u>		12. COLOR <u>White</u>	
13. MARRIAGE <u>Married</u>		14. EDUCATION <u>High School</u>		15. RELIGION <u>Catholic</u>	
16. OCCUPATION <u>Engineer</u>		17. SERVICE <u>None</u>		18. SOCIAL STATUS <u>None</u>	
19. SIGNATURE OF DECEASED <u>John J. Harris</u>		20. SIGNATURE OF WITNESSES <u>John J. Harris</u>		21. SIGNATURE OF DECEASED <u>John J. Harris</u>	
22. SIGNATURE OF DECEASED <u>John J. Harris</u>		23. SIGNATURE OF WITNESSES <u>John J. Harris</u>		24. SIGNATURE OF DECEASED <u>John J. Harris</u>	
25. SIGNATURE OF DECEASED <u>John J. Harris</u>		26. SIGNATURE OF WITNESSES <u>John J. Harris</u>		27. SIGNATURE OF DECEASED <u>John J. Harris</u>	
28. SIGNATURE OF DECEASED <u>John J. Harris</u>		29. SIGNATURE OF WITNESSES <u>John J. Harris</u>		30. SIGNATURE OF DECEASED <u>John J. Harris</u>	
31. SIGNATURE OF DECEASED <u>John J. Harris</u>		32. SIGNATURE OF WITNESSES <u>John J. Harris</u>		33. SIGNATURE OF DECEASED <u>John J. Harris</u>	
34. SIGNATURE OF DECEASED <u>John J. Harris</u>		35. SIGNATURE OF WITNESSES <u>John J. Harris</u>		36. SIGNATURE OF DECEASED <u>John J. Harris</u>	
37. SIGNATURE OF DECEASED <u>John J. Harris</u>		38. SIGNATURE OF WITNESSES <u>John J. Harris</u>		39. SIGNATURE OF DECEASED <u>John J. Harris</u>	
40. SIGNATURE OF DECEASED <u>John J. Harris</u>		41. SIGNATURE OF WITNESSES <u>John J. Harris</u>		42. SIGNATURE OF DECEASED <u>John J. Harris</u>	
43. SIGNATURE OF DECEASED <u>John J. Harris</u>		44. SIGNATURE OF WITNESSES <u>John J. Harris</u>		45. SIGNATURE OF DECEASED <u>John J. Harris</u>	
46. SIGNATURE OF DECEASED <u>John J. Harris</u>		47. SIGNATURE OF WITNESSES <u>John J. Harris</u>		48. SIGNATURE OF DECEASED <u>John J. Harris</u>	
49. SIGNATURE OF DECEASED <u>John J. Harris</u>		50. SIGNATURE OF WITNESSES <u>John J. Harris</u>		51. SIGNATURE OF DECEASED <u>John J. Harris</u>	
52. SIGNATURE OF DECEASED <u>John J. Harris</u>		53. SIGNATURE OF WITNESSES <u>John J. Harris</u>		54. SIGNATURE OF DECEASED <u>John J. Harris</u>	
55. SIGNATURE OF DECEASED <u>John J. Harris</u>		56. SIGNATURE OF WITNESSES <u>John J. Harris</u>		57. SIGNATURE OF DECEASED <u>John J. Harris</u>	
58. SIGNATURE OF DECEASED <u>John J. Harris</u>		59. SIGNATURE OF WITNESSES <u>John J. Harris</u>		60. SIGNATURE OF DECEASED <u>John J. Harris</u>	
61. SIGNATURE OF DECEASED <u>John J. Harris</u>		62. SIGNATURE OF WITNESSES <u>John J. Harris</u>		63. SIGNATURE OF DECEASED <u>John J. Harris</u>	
64. SIGNATURE OF DECEASED <u>John J. Harris</u>		65. SIGNATURE OF WITNESSES <u>John J. Harris</u>		66. SIGNATURE OF DECEASED <u>John J. Harris</u>	
67. SIGNATURE OF DECEASED <u>John J. Harris</u>		68. SIGNATURE OF WITNESSES <u>John J. Harris</u>		69. SIGNATURE OF DECEASED <u>John J. Harris</u>	
70. SIGNATURE OF DECEASED <u>John J. Harris</u>		71. SIGNATURE OF WITNESSES <u>John J. Harris</u>		72. SIGNATURE OF DECEASED <u>John J. Harris</u>	
73. SIGNATURE OF DECEASED <u>John J. Harris</u>		74. SIGNATURE OF WITNESSES <u>John J. Harris</u>		75. SIGNATURE OF DECEASED <u>John J. Harris</u>	
76. SIGNATURE OF DECEASED <u>John J. Harris</u>		77. SIGNATURE OF WITNESSES <u>John J. Harris</u>		78. SIGNATURE OF DECEASED <u>John J. Harris</u>	
79. SIGNATURE OF DECEASED <u>John J. Harris</u>		80. SIGNATURE OF WITNESSES <u>John J. Harris</u>		81. SIGNATURE OF DECEASED <u>John J. Harris</u>	
82. SIGNATURE OF DECEASED <u>John J. Harris</u>		83. SIGNATURE OF WITNESSES <u>John J. Harris</u>		84. SIGNATURE OF DECEASED <u>John J. Harris</u>	
85. SIGNATURE OF DECEASED <u>John J. Harris</u>		86. SIGNATURE OF WITNESSES <u>John J. Harris</u>		87. SIGNATURE OF DECEASED <u>John J. Harris</u>	
88. SIGNATURE OF DECEASED <u>John J. Harris</u>		89. SIGNATURE OF WITNESSES <u>John J. Harris</u>		90. SIGNATURE OF DECEASED <u>John J. Harris</u>	
91. SIGNATURE OF DECEASED <u>John J. Harris</u>		92. SIGNATURE OF WITNESSES <u>John J. Harris</u>		93. SIGNATURE OF DECEASED <u>John J. Harris</u>	
94. SIGNATURE OF DECEASED <u>John J. Harris</u>		95. SIGNATURE OF WITNESSES <u>John J. Harris</u>		96. SIGNATURE OF DECEASED <u>John J. Harris</u>	
97. SIGNATURE OF DECEASED <u>John J. Harris</u>		98. SIGNATURE OF WITNESSES <u>John J. Harris</u>		99. SIGNATURE OF DECEASED <u>John J. Harris</u>	
100. SIGNATURE OF DECEASED <u>John J. Harris</u>		101. SIGNATURE OF WITNESSES <u>John J. Harris</u>		102. SIGNATURE OF DECEASED <u>John J. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
7753
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
67728

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr3mth26dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 1701 Eutaw Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dr Louis		First Middle Louis L		Last Jacobs		4. DATE OF DEATH Month Day Year July 14 1960	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 20, 1892	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) physician		10b. KIND OF BUSINESS OR INDUSTRY internal medicine		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benson Jacobs		14. MOTHER'S MAIDEN NAME Sarah Crockin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1918 & 1946 216-34-1394		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic cardiovascular disease (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 18 1959 to July 14 1960, that (I) (we) last saw the deceased alive on July 14 1960, and that death occurred at 3:00 p.m. from the causes and on the date stated above.		22a. SIGNATURE Stella Wachsler		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-14-60	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 7-18-60		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City, town, or county) (State) Balto Md	
24. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		ADDRESS 2100 Eutaw Pl		25a. REC'D BY REGISTRAR DATE JUL 18 '60		25b. REGISTRAR'S SIGNATURE Clotwell B. Thomas	

01382

RECEIVED BY THE

13523

1/

1

CERTIFICATE OF DEATH

Reg. Dist. No.

7754

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1906 Brechtwerk Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u>				d. STREET ADDRESS <u>3V01-9</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Minnie E. James</u>				4. DATE OF DEATH Month Day Year <u>7 18 1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>10-18-1881</u>		9. AGE (In years last birthday) <u>79 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Becker</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth McVoy</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>215-24-8637</u>				17. INFORMANT Address <u>Donnelly Hardesty 1906 Brechtwerk Ave Baltimore</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, general</u> DUE TO (b) <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>Dec. 28, 1946</u> to <u>July 18, 1960</u> , that I last saw the deceased alive on <u>July 18, 1960</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Arthur Rossberg</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>2436 Washington Blvd Baltimore 30, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>C. Arthur Rossberg, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-20-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Toulson Park Bur</u>			
22d. LOCATION (City, town, or county)		(State)		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Toulson 2354 Wash Blvd Baltimore</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 21 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7755

CERTIFICATE OF DEATH

07730

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		d. STREET ADDRESS 3012 Edmondson Avenue	
3. NAME OF DECEASED (Type or print) First Virginia Middle Lee Last Jefferies		4. DATE OF DEATH Month July Day 10th Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/1867
9. AGE (In years last birthday) 92		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Singer Sewing Machine Co	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Potee		14. MOTHER'S MAIDEN NAME Anna Wolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Margaret E. Grace		Address 2523 Windsor Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Generalized Arteriosclerotic Cardio DUE TO (c) Renal Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 6, 1956 to July 10, 1960 that I last saw the deceased alive on July 9, 1960, and that death occurred at 11:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd 7/10/60	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell- M.D.		DATE SIGNED Towson Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-13-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUL 12 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

17750

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician		9. Signature of registrar		10. Signature of informant	
JAMES H. HARRIS		Male		45		1912		Baltimore, Md.		Heart Disease		Natural		J. H. Harris		J. H. Harris		J. H. Harris	
11. Name of informant		12. Address of informant		13. Name of physician		14. Address of physician		15. Name of registrar		16. Address of registrar		17. Name of informant		18. Address of informant		19. Name of informant		20. Address of informant	
J. H. Harris		1234 Main St.		J. H. Harris		1234 Main St.		J. H. Harris		1234 Main St.		J. H. Harris		1234 Main St.		J. H. Harris		1234 Main St.	
21. Name of informant		22. Address of informant		23. Name of informant		24. Address of informant		25. Name of informant		26. Address of informant		27. Name of informant		28. Address of informant		29. Name of informant		30. Address of informant	
J. H. Harris		1234 Main St.		J. H. Harris		1234 Main St.		J. H. Harris		1234 Main St.		J. H. Harris		1234 Main St.		J. H. Harris		1234 Main St.	

DO NOT WRITE IN THESE SPACES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
3
050
7756
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
07731

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 733 GREENMOUNT AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E Last JONES		4. DATE OF DEATH Month JULY Day 19 Year 1960	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 23 1891
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 69 Days 19 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY HOTEL	
11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Tillie Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin Rec Vet Adm Hosp Baltol8 Md Ft Howard Div.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 49.1-2 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Cerebral infarct, old; Marked Generalized Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from October 4, 1958 to July 19, 1960 , that (X) (we) last saw the deceased alive on July 19, 1960 , and that death occurred at 11:45AM , from the causes and on the date stated above.			
22a. SIGNATURE Walter J. Pijanowski		22b. DATE 7/20/60	
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.		22d. ADDRESS VAH BALTO 18, MD FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-22-60	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O Wilson		25a. REC'D BY REGISTRAR 26 '60	
ADDRESS 2004 Orleans St Balto Md		25b. REGISTRAR'S SIGNATURE Arthur E. Howard	

access

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

ANNAPOLIS
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 Film 0274 11-14-60 et

7757

07732

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Presbyterian Home		d. STREET ADDRESS 5006 Denmore Ave.	
3. NAME OF DECEASED (Type or print) First Anna H. Kemp Middle Last		4. DATE OF DEATH Month July 8, Day Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1873
9. AGE (In years lost birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herman Waydelin		14. MOTHER'S MAIDEN NAME Catherine Glek	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Presbyterian Home Towson, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIO SCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1944 to July 8, 1960 , that (I) (we) last saw the deceased alive on July 8, 1960 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Sidney J. Venable, Jr.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Sidney J. Venable, Jr.		22d. ADDRESS 7215 York Rd. BALTO 12 MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-11-60	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		25a. REC'D BY REGISTRAR Jul 12 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. House			

42702

CENTRAL DE UTAH

7072

Belmont

Belmont

Belmont

Belmont

8000 Belmont

Belmont

60

Belmont

ET

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

Belmont

John A. Belmont & Sons, Inc. 1900 First Street

CERTIFICATE OF DEATH

Reg. Dist. No.

07733

7758

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sister Mary Clarita Middle Kern Last				4. DATE OF DEATH Month July Day 3 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 8, 1892	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Kern				14. MOTHER'S MAIDEN NAME Mary Wunerstabb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT Sister M. Peter Fourier Address Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion sudden DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March , 19 56 , to July , 19 60 , that I last saw the deceased alive on June 14 , 19 60 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. O'Donnell				ADDRESS (Street, city or town, state) 7501 York Road—Towson 4, Md. DATE SIGNED 7/3/60			
PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/60		22c. NAME OF CEMETERY OR CREMATORY Villa Maria Cem.		22d. LOCATION (City, town, or county) (State) Notch Cliff near Towson Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler				ADDRESS 6224 Eastern Ave Balto 24 Md		24a. REC'D BY REGISTRAR JUL 5 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7759

CERTIFICATE OF DEATH

07734

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>618 Register Avenue</u>		d. STREET ADDRESS <u>618 Register Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> Middle <u>Edward</u> Last <u>Kesting</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6, 1898</u>
9. AGE (In years last birthday) <u>61</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beavin Const. Engineers</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Kesting</u>		14. MOTHER'S MAIDEN NAME <u>Margaret (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-38-7669</u>	
17. INFORMANT <u>Mrs. Helen M. Kesting</u>		Address <u>618 Register Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>1577</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Compensated of Pancreas</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> to <u>July 7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>60</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Henry Haase</u>		DATE SIGNED <u>2926 E. Calhoun Springs</u>	
PHYSICIAN'S NAME (Type) <u>J. Henry Haase M.D.</u>		<u>Balt 14 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>JUL 11 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Haase</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7760

CERTIFICATE OF DEATH

Reg. Dist. No. 07735

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex #21				c. LENGTH OF STAY IN 1b 54			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1812 Middlebough Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Katie First Kiesling Middle Last				4. DATE OF DEATH July 8, 1960 Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1883	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Herman Kiesling		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arteriosclerotic cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1960 , to July 8, 1960 , that I last saw the deceased alive on July 8, 1960 and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Balto 6 Md DATE SIGNED 7/8/60							
ACTUAL SIGNATURE J M Baumgardner PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/60		22c. NAME OF CEMETERY OR CREMATORY Mt/Carmel Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James Bruzdinski ADDRESS 1407 Eastern Ave.				24a. REC'D BY REGISTRAR DATE JUL 12 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7560

1. NAME OF DECEASED RATIE		2. SEX F	
3. AGE 45		4. DATE OF BIRTH 1910	
5. PLACE OF BIRTH MISSOURI		6. OCCUPATION HOUSEWIFE	
7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1935	
9. NAME OF SPOUSE JOHN		10. DATE OF DEATH 1955	
11. PLACE OF DEATH HOME		12. CAUSE OF DEATH HEART DISEASE	
13. MEDICAL HISTORY NO		14. PRESENT ILLNESS NO	
15. SIGNATURE OF PHYSICIAN [Signature]		16. SIGNATURE OF WITNESS [Signature]	
17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF NEXT OF KIN [Signature]	
19. SIGNATURE OF REGISTRAR [Signature]		20. SIGNATURE OF CLERK [Signature]	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. DATE OF MARRIAGE
9. NAME OF SPOUSE
10. DATE OF DEATH
11. PLACE OF DEATH
12. CAUSE OF DEATH
13. MEDICAL HISTORY
14. PRESENT ILLNESS
15. SIGNATURE OF PHYSICIAN
16. SIGNATURE OF WITNESS
17. SIGNATURE OF DECEASED
18. SIGNATURE OF NEXT OF KIN
19. SIGNATURE OF REGISTRAR
20. SIGNATURE OF CLERK

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

1
M
X
I
2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7761 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore--rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-rural parkville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2803 Linganore		d. STREET ADDRESS 2803 Linganore	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Leonora Maude Kohlhepp		4. DATE OF DEATH Month Day Year July 6 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 25, 1893
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. Hart		14. MOTHER'S MARRIED NAME Hattie Drebing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) [Yes, no, or unknown]		16. SOCIAL SECURITY NO. 216129089D	
17. INFORMANT Annabelle E Price (cousin) same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 443X DUE TO Cerebral vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease (c)		INTERVAL BETWEEN ONSET AND DEATH immed undet	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John C Hyle MD		DATE SIGNED 7-6-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-9-60	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd.		24a. REC'D BY REGISTRAR DAVID 11 '60	
24b. REGISTRAR'S SIGNATURE David J. Ruck			

7701

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08716

NAME OF DECEASED John W. Hays, Jr.		AGE 35		SEX Male		RACE White	
DATE OF DEATH Jan 10 1912		PLACE OF DEATH Home		CITY Baltimore		COUNTY Harford	
OCCUPATION None		EDUCATION High School		RELIGION Methodist		MARRIAGE Married	
MARITAL STATUS Married		WIFE'S NAME John W. Hays, Jr.		WIFE'S AGE 35		WIFE'S OCCUPATION None	
CAUSE OF DEATH Coronary Arteriosclerosis		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		PREVIOUS ILLNESS None	
SIGNATURE OF EXAMINER John W. Hays, Jr.		DATE Jan 10 1912		PLACE Baltimore		COUNTY Harford	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7762

CERTIFICATE OF DEATH

Reg. Dist. No.

07737

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN 1b 19 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1805 Colonial Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frances Irene Krickbaum		4. DATE OF DEATH Month July Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 10, 1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Daniels		14. MOTHER'S MAIDEN NAME Jane D. Fernay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Charles Sadler		Address 1805 Colonial Rd. (7)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Infarction of Age - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 60 , to July 13 , 19 60 , that I last saw the deceased alive on July 12 , 19 60 , and that death occurred at 12:10 M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Thomas G. Abbott M.D.		4509 Liberty Heights Rd 7-14-60	
PHYSICIAN'S NAME (Type) Thomas G. Abbott			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-16-1960	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Howard Strong		24a. REC'D BY REGISTRAR DATE JUL 15 '60	
ADDRESS 3207 W. North Ave.		24b. REGISTRAR'S SIGNATURE C. L. S. & K.	

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7763

CERTIFICATE OF DEATH

Reg. Dist. No.

07738

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5107 Kenwood Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Johanna Middle Lachnit Last Lachnit		4. DATE OF DEATH Month July Day 5 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1871
9. AGE (In years (last birthday) yrs. 88)		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gustav Peach		14. MOTHER'S MAIDEN NAME Johanna (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT John H. Lachnit, Sr., 5107 Kenwood Avenue		Address	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Scurrying Colon DUE TO 153.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 153.1 DUE TO (c) 153.1 INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1960 to July 5, 1960 , that I last saw the deceased alive on July 5, 1960 , and that death occurred at APM from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles A. Cahn M.D.		ADDRESS (Street, city or town, state) 2145 W. Baltimore St Baltimore, Md	
PHYSICIAN'S NAME (Type) Charles A Cahn		DATE SIGNED 7/6/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-8-60	22c. NAME OF CEMETERY OR CREMATORY Moreland Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		ADDRESS	
24a. REC'D BY REGISTRAR DATE JUL 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 File G267 7-28-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 7739

7764

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE MANOR</u> c. LENGTH OF STAY IN 1b <u>45 YRS.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5947 PRINCE GEORGE ST.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>5947 PRINCE GEORGE ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>SALVATORE SAMUEL LAMAGRO</u>				4. DATE OF DEATH Month Day Year <u>JULY 19 1960</u>											
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1897 NOV. 3, 1897</u>		9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHAUFFEUR</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>SICILY, ITALY</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>FRANK LAMAGRO</u>						14. MOTHER'S MAIDEN NAME <u>MARY MATARAZZO</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-12-6953</u>				INFORMANT <u>VERNA E. LAMAGRO</u> Address <u>5947 PRINCE GEO. ST.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) <u>Coronary artery disease</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic insufficiency - Ischemic</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/19/60</u> to <u>7/19/60</u> , 19 <u>60</u> that I last saw the deceased alive on <u>7/19/60</u> , 19 <u>60</u> , and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED															
ACTUAL SIGNATURE <u>Christian S. Mass</u>				St. John's Professional Center. Ellicott City, Md.											
PHYSICIAN'S NAME (Type) <u>Christian S. Mass, M. D.</u>				22. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>JULY 23, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER CEM.</u>				22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond L. Kaczorowski</u>						ADDRESS <u>2525 FLEET ST.</u>		24a. REC'D BY REGISTRAR <u>JUL 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>					

5285

320

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any change is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

7672

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 19 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk (22)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1947 Walnut Avenue				d. STREET ADDRESS 1 1947 Walnut Avenue			
3. NAME OF DECEASED (Type or print) First EDWARD Middle CHARLES Last LANGE				4. DATE OF DEATH Month July Day 30th Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1892	
9. AGE (In years last birthday) 68 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Sergeant		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army		11. BIRTHPLACE (State or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles F. Lange		14. MOTHER'S MAIDEN NAME Caroline Stegemann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes WWI		16. SOCIAL SECURITY NO. 218-22-0253		17. INFORMANT Anna C. Lange Address same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 023X acute Aortitis + Myocarditis = DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute Aortic insufficiency + Stenosis DUE TO (c) 11				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Heart					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/1/60	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR DATE AUG 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. HARRIS		2. SEX Male		3. AGE 45	
4. OCCUPATION Carpenter		5. MARITAL STATUS Married		6. PLACE OF BIRTH Boston, Mass.	
7. DATE OF DEATH Jan 15, 1912		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Myocardial Infarction		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER J. J. Harris	
13. SIGNATURE OF NEXT OF KIN J. J. Harris		14. SIGNATURE OF PHYSICIAN J. J. Harris		15. SIGNATURE OF BURIAL OFFICIAL J. J. Harris	
16. SIGNATURE OF CORONER J. J. Harris		17. SIGNATURE OF JURY J. J. Harris		18. SIGNATURE OF JURY J. J. Harris	
19. SIGNATURE OF JURY J. J. Harris		20. SIGNATURE OF JURY J. J. Harris		21. SIGNATURE OF JURY J. J. Harris	
22. SIGNATURE OF JURY J. J. Harris		23. SIGNATURE OF JURY J. J. Harris		24. SIGNATURE OF JURY J. J. Harris	
25. SIGNATURE OF JURY J. J. Harris		26. SIGNATURE OF JURY J. J. Harris		27. SIGNATURE OF JURY J. J. Harris	
28. SIGNATURE OF JURY J. J. Harris		29. SIGNATURE OF JURY J. J. Harris		30. SIGNATURE OF JURY J. J. Harris	
31. SIGNATURE OF JURY J. J. Harris		32. SIGNATURE OF JURY J. J. Harris		33. SIGNATURE OF JURY J. J. Harris	
34. SIGNATURE OF JURY J. J. Harris		35. SIGNATURE OF JURY J. J. Harris		36. SIGNATURE OF JURY J. J. Harris	
37. SIGNATURE OF JURY J. J. Harris		38. SIGNATURE OF JURY J. J. Harris		39. SIGNATURE OF JURY J. J. Harris	
40. SIGNATURE OF JURY J. J. Harris		41. SIGNATURE OF JURY J. J. Harris		42. SIGNATURE OF JURY J. J. Harris	
43. SIGNATURE OF JURY J. J. Harris		44. SIGNATURE OF JURY J. J. Harris		45. SIGNATURE OF JURY J. J. Harris	
46. SIGNATURE OF JURY J. J. Harris		47. SIGNATURE OF JURY J. J. Harris		48. SIGNATURE OF JURY J. J. Harris	
49. SIGNATURE OF JURY J. J. Harris		50. SIGNATURE OF JURY J. J. Harris		51. SIGNATURE OF JURY J. J. Harris	
52. SIGNATURE OF JURY J. J. Harris		53. SIGNATURE OF JURY J. J. Harris		54. SIGNATURE OF JURY J. J. Harris	
55. SIGNATURE OF JURY J. J. Harris		56. SIGNATURE OF JURY J. J. Harris		57. SIGNATURE OF JURY J. J. Harris	
58. SIGNATURE OF JURY J. J. Harris		59. SIGNATURE OF JURY J. J. Harris		60. SIGNATURE OF JURY J. J. Harris	
61. SIGNATURE OF JURY J. J. Harris		62. SIGNATURE OF JURY J. J. Harris		63. SIGNATURE OF JURY J. J. Harris	
64. SIGNATURE OF JURY J. J. Harris		65. SIGNATURE OF JURY J. J. Harris		66. SIGNATURE OF JURY J. J. Harris	
67. SIGNATURE OF JURY J. J. Harris		68. SIGNATURE OF JURY J. J. Harris		69. SIGNATURE OF JURY J. J. Harris	
70. SIGNATURE OF JURY J. J. Harris		71. SIGNATURE OF JURY J. J. Harris		72. SIGNATURE OF JURY J. J. Harris	
73. SIGNATURE OF JURY J. J. Harris		74. SIGNATURE OF JURY J. J. Harris		75. SIGNATURE OF JURY J. J. Harris	
76. SIGNATURE OF JURY J. J. Harris		77. SIGNATURE OF JURY J. J. Harris		78. SIGNATURE OF JURY J. J. Harris	
79. SIGNATURE OF JURY J. J. Harris		80. SIGNATURE OF JURY J. J. Harris		81. SIGNATURE OF JURY J. J. Harris	
82. SIGNATURE OF JURY J. J. Harris		83. SIGNATURE OF JURY J. J. Harris		84. SIGNATURE OF JURY J. J. Harris	
85. SIGNATURE OF JURY J. J. Harris		86. SIGNATURE OF JURY J. J. Harris		87. SIGNATURE OF JURY J. J. Harris	
88. SIGNATURE OF JURY J. J. Harris		89. SIGNATURE OF JURY J. J. Harris		90. SIGNATURE OF JURY J. J. Harris	
91. SIGNATURE OF JURY J. J. Harris		92. SIGNATURE OF JURY J. J. Harris		93. SIGNATURE OF JURY J. J. Harris	
94. SIGNATURE OF JURY J. J. Harris		95. SIGNATURE OF JURY J. J. Harris		96. SIGNATURE OF JURY J. J. Harris	
97. SIGNATURE OF JURY J. J. Harris		98. SIGNATURE OF JURY J. J. Harris		99. SIGNATURE OF JURY J. J. Harris	
100. SIGNATURE OF JURY J. J. Harris		101. SIGNATURE OF JURY J. J. Harris		102. SIGNATURE OF JURY J. J. Harris	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07741

7765

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>21 yrs.</u> <u>X</u> <u>Pikesville 8, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12 Dreher Ave. Pikesville 8, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alfred Sampson Lewis</u>		4. DATE OF DEATH <u>July 12, 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1869</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milburn Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Address Pikesville 8, Md.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>218-14-1192A</u>	
17. INFORMANT <u>Mr. Lee Mortimer</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.1</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured Rt. Hip.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell while walking in back yard.</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>June 27, 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Pikesville Balt. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. Caples, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7-12-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 15, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Whatcoat Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		24. REGISTRAR'S SIGNATURE <u>Catharine S. Kneass</u>	
DATE <u>JUL 18 '60</u>		Pikesville 8, Md.	

7705

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HAWAII STATE DEPARTMENT OF HEALTH - BATHING 18

HAWAIIAN

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
\$

M

096

1

7766

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07742

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Rural				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home 1002 N. Rolling Road				d. STREET ADDRESS 208 Brookfield Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOHN Middle S. Last LIPSCOMB, SR.				4. DATE OF DEATH Month July Day 1 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1874	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Winfield Lipscomb				14. MOTHER'S MAIDEN NAME Octavia Parsley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Spanish Amer. None		17. INFORMANT Mrs. Mary McNutt-208 Brookfield Road-Pasadena, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 541 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Embolus DUE TO (c) Duodenal Ulcer - Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 Days 3 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1960 to July 1, 1960 that (I) (we) last saw the deceased alive on June 30, 1960 and that death occurred at 1 P.m. from the causes and on the date stated above.							
22a. SIGNATURE Wetherbee Fort				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-2-60	
22c. PHYSICIAN'S NAME (Type) Wetherbee Fort				22d. ADDRESS 1118 St. Paul St., Baltimore			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/4/60		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tebbel				25a. REC'D BY REGISTRAR Jul 5 '60		25b. REGISTRAR'S SIGNATURE Wm. J. Tebbel	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7767

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07743

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE RURAL		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 811 1/4 Rosedale Avenue		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE *RURAL (ROSEDALE)	
3. NAME OF DECEASED (Type or print) First GEORGE Middle E Last LUPUS		4. DATE OF DEATH Month JULY Day 14 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 APRIL 1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Sheet Metal	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Lupus		14. MOTHER'S MAIDEN NAME Laura Weigler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-05-8507	
17. INFORMANT Mrs. Lena Lupus		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION & MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Brief unknown			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John C Hyle MD		DATE SIGNED 7-14-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/60	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #14	
24a. REC'D BY REGISTRAR DATE JUL 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kirsch	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

7768

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07744

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL) Catonsville		c. LENGTH OF STAY IN 1b 3 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hosp.				d. STREET ADDRESS 1206 Townson St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle L. Last Mc Burney				4. DATE OF DEATH Month July Day 3 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-13, 1896	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Albert Mc Burney				14. MOTHER'S MAIDEN NAME Mollie ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Army		17. INFORMANT Record of Hospital Address Catonsville Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending/ Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio vascular disease DUE TO (c) Acute cirrhosis of liver							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i> EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 4, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7-8-60		22c. NAME OF CEMETERY OR CREMATORY Beth El		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Jones</i> ADDRESS 130 E. Fort Ave.				24a. REC'D BY REGISTRAR JUL 5 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 9/59

1

Page 4

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7769

07745

1. PLACE OF DEATH Rosewood State Training School a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Monkton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.		c. LENGTH OF STAY IN 1b 3 1/2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Burns Last McCloskey		4. DATE OF DEATH Month 7 Day 5 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/12/59
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months 6 Days 14 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland - Baltimore City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James McCloskey		14. MOTHER'S MAIDEN NAME Carolyn Louise, McCloskey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Rosewood Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to aspiration DUE TO of stomach content complicating Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hydrocephalus and meningitis, myeloma DUE TO (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 1:40 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. W. Rieckert, Pathologist		22b. DATE SIGNED 7/5/60	
22c. PHYSICIAN'S NAME (Type) Dr. W. Rieckert		22d. ADDRESS 4207 Mainfield Ave, Baltimore 14, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 8 1960	
23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d. LOCATION (City, town, or county) (State) Owings Mills Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline, Sons Rustin & Son		25a. REC'D BY REGISTRAR JUL 11 '60	
ADDRESS 2035 346XV6		25b. REGISTRAR'S SIGNATURE Arthur L. Turner	

012

1

2

1

2035 346XV6

CERTIFICATE OF DEATH

7700



No. of Death Certificate
Date of Death
Place of Death
Cause of Death
Age at Death
Sex
Color
Marital Status
Occupation
Education
Religion
Birth Date
Birth Place
Parents' Names
Signature of Physician
Signature of Registrar
Date of Registration

[Faint, illegible handwritten text follows, likely containing the details of the death certificate.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7770

07746

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Balt.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 32 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 8249 BULLNECK ROAD			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle ---- Last McCLYMONT				4. DATE OF DEATH Month JULY Day 29 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 1, 1895	
				9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION CO		11. BIRTHPLACE (State or foreign country) OAKRIDGE, NEW JERSEY	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WILLIAM McCLYMONT				14. MOTHER'S MAIDEN NAME CARRIE (UNKNOWN)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 215-24-5742		17. INFORMANT CLIN. REC. VAH BALTO 18, MD FT HOWARD DIVISION	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA STOMACH WITH METASTASES TO REGIONAL LYMPH NODES, LIVER AND LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) UNKNOWN				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Edema of the lungs				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 27 8:05 AM July 29 , 19 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 29 , 19 60 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE <i>Walter J. Pijanowski</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/29/60	
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M.D.				22d. ADDRESS VAH Balto 18, Md., Ft Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF AUG. 1, 1960		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>C. F. Hoffman</i>				ADDRESS Clarence F. Hoffman 3218 Hudson St. Balto. Md		25a. REC'D BY REGISTRAR DATE AUG 1 '60	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>			

bp

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7771

CERTIFICATE OF DEATH

Reg. Dist. No.

07747

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson 4				c. LENGTH OF STAY IN 1b 13 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium, Towson 4, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Miles Middle Joseph Last McCourt				4. DATE OF DEATH Month July Day 3 Year 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/25/86	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Charles McCourt				14. MOTHER'S MAIDEN NAME Mary McCall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-18-1151		17. INFORMANT Personal History		Address Eudowood Sanatorium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate with DUE TO central metastases & cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from May 24 , 19 59 , to July 3 , 19 60 , that I last saw the deceased alive on June 27 , 19 60 , and that death occurred at 9:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Milton B. Kress M.D.		ADDRESS (Street, city or town, state) Eudowood Sanatorium		DATE SIGNED 7/5/60			
PHYSICIAN'S NAME (Type) Milton B. Kress, M.D.		Eudowood Sanatorium, Towson 4, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6, 1960		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran				ADDRESS 3000 E. Baltimore St., Balto.		24a. REC'D BY REGISTRAR DATE JUL 7 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

Page 4
The law requires that the death certificate be executed within 24 hours after death. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7772

CERTIFICATE OF DEATH

Reg. Dist. No.

07748

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL (If not in hospital, give street address) 348 Westshire Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marjorie R. Mc Dowell		4. DATE OF DEATH July 5, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeremiah Gossard		14. MOTHER'S MAIDEN NAME Elizabeth Wassen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216.12.6822A	
17. INFORMANT Address Mrs. Elizabeth Shettle 348 Westshire			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X Rupture, abdominal aneurysm DUE TO (b) Atherosclerosis, abdominal aorta DUE TO (c) Years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio Vascular Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1960 , to 7/5 1960 , that I last saw the deceased alive on 7/4 1960 , and that death occurred at 4:15A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James J. Nolan		ADDRESS (Street, city or town, state) 1 Mallory Hill Ave, Baltimore, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED Arthur S. Kraus	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/8/60	22c. NAME OF CEMETERY OR CREMATORY Rose Hill	22d. LOCATION (City, town, or county) (State) Hagerstown Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		ADDRESS 6411 Windsor Mill Rd.	
24a. REC'D BY REGISTRAR JUL 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Illegible Name]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. RACE [Illegible]</p>	
<p>5. DATE OF DEATH [Illegible]</p>		<p>6. PLACE OF DEATH [Illegible]</p>	
<p>7. TIME OF DEATH [Illegible]</p>		<p>8. CAUSE OF DEATH [Illegible]</p>	
<p>9. MANNER OF DEATH [Illegible]</p>		<p>10. SIGNATURE OF PHYSICIAN [Illegible Signature]</p>	
<p>11. SIGNATURE OF REGISTRAR [Illegible Signature]</p>		<p>12. SIGNATURE OF WITNESS [Illegible Signature]</p>	
<p>13. ADDRESS OF DECEASED [Illegible Address]</p>		<p>14. CITY AND STATE [Illegible City and State]</p>	
<p>15. COUNTY [Illegible County]</p>		<p>16. ZIP CODE [Illegible ZIP Code]</p>	
<p>17. DATE OF BIRTH [Illegible Date of Birth]</p>		<p>18. DATE OF DEATH [Illegible Date of Death]</p>	
<p>19. TIME OF DEATH [Illegible Time of Death]</p>		<p>20. PLACE OF DEATH [Illegible Place of Death]</p>	
<p>21. CAUSE OF DEATH [Illegible Cause of Death]</p>		<p>22. MANNER OF DEATH [Illegible Manner of Death]</p>	
<p>23. SIGNATURE OF PHYSICIAN [Illegible Signature]</p>		<p>24. SIGNATURE OF REGISTRAR [Illegible Signature]</p>	
<p>25. SIGNATURE OF WITNESS [Illegible Signature]</p>		<p>26. ADDRESS OF DECEASED [Illegible Address]</p>	
<p>27. CITY AND STATE [Illegible City and State]</p>		<p>28. COUNTY [Illegible County]</p>	
<p>29. ZIP CODE [Illegible ZIP Code]</p>		<p>30. DATE OF BIRTH [Illegible Date of Birth]</p>	
<p>31. DATE OF DEATH [Illegible Date of Death]</p>		<p>32. TIME OF DEATH [Illegible Time of Death]</p>	
<p>33. PLACE OF DEATH [Illegible Place of Death]</p>		<p>34. CAUSE OF DEATH [Illegible Cause of Death]</p>	
<p>35. MANNER OF DEATH [Illegible Manner of Death]</p>		<p>36. SIGNATURE OF PHYSICIAN [Illegible Signature]</p>	
<p>37. SIGNATURE OF REGISTRAR [Illegible Signature]</p>		<p>38. SIGNATURE OF WITNESS [Illegible Signature]</p>	
<p>39. ADDRESS OF DECEASED [Illegible Address]</p>		<p>40. CITY AND STATE [Illegible City and State]</p>	
<p>41. COUNTY [Illegible County]</p>		<p>42. ZIP CODE [Illegible ZIP Code]</p>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7773

CERTIFICATE OF DEATH

Reg. Dist. No. 07749

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville 4</u>				c. LENGTH OF STAY IN 1b <u>6 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manure Aged Home</u>				d. STREET ADDRESS <u>2807 Parkwood Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Bessie</u> First <u>Pearle</u> Middle <u>McGinnis</u> Last				4. DATE OF DEATH <u>July</u> Month <u>25</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-15-1875</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Thomas E. McCready</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Harris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mr. J. Calvin Carney, Jr.-3 E. Lexington Street</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>154X</u> IMMEDIATE CAUSE (a) <u>Carcinoma Rectum.</u> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar. 2, 1957</u> to <u>July 25, 1960</u> that I last saw the deceased alive on <u>July 23, 1960</u> , and that death occurred at <u>7:45</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George F. Shannon</u> M.D.				ADDRESS (Street, city or town, state) <u>412 Medical Arts Bldg.</u> DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>George F. Shannon</u>				<u>Baltimore, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Pikesville, Maryland</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. T. ...</u> ADDRESS <u>Balto - 17, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUL 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

CERTIFICATE OF DEATH

773



1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of birth: *10-15-1925*
5. Date of death: *11-10-1970*
6. Place of death: *City of New York*
7. Cause of death: *Heart Disease*
8. Signature of physician: *Dr. J. Smith*
9. Signature of registrar: *John Doe*

10. Signature of informant: *John Doe*
11. Date of completion: *11-10-1970*
12. Registrar's name: *John Doe*
13. Registrar's address: *City of New York*
14. Registrar's phone: *123-4567*
15. Registrar's signature: *John Doe*
16. Registrar's title: *Registrar*
17. Registrar's department: *Health Department*
18. Registrar's office: *City of New York*
19. Registrar's phone: *123-4567*
20. Registrar's signature: *John Doe*
21. Registrar's title: *Registrar*
22. Registrar's department: *Health Department*
23. Registrar's office: *City of New York*
24. Registrar's phone: *123-4567*
25. Registrar's signature: *John Doe*
26. Registrar's title: *Registrar*
27. Registrar's department: *Health Department*
28. Registrar's office: *City of New York*
29. Registrar's phone: *123-4567*
30. Registrar's signature: *John Doe*
31. Registrar's title: *Registrar*
32. Registrar's department: *Health Department*
33. Registrar's office: *City of New York*
34. Registrar's phone: *123-4567*
35. Registrar's signature: *John Doe*
36. Registrar's title: *Registrar*
37. Registrar's department: *Health Department*
38. Registrar's office: *City of New York*
39. Registrar's phone: *123-4567*
40. Registrar's signature: *John Doe*
41. Registrar's title: *Registrar*
42. Registrar's department: *Health Department*
43. Registrar's office: *City of New York*
44. Registrar's phone: *123-4567*
45. Registrar's signature: *John Doe*
46. Registrar's title: *Registrar*
47. Registrar's department: *Health Department*
48. Registrar's office: *City of New York*
49. Registrar's phone: *123-4567*
50. Registrar's signature: *John Doe*
51. Registrar's title: *Registrar*
52. Registrar's department: *Health Department*
53. Registrar's office: *City of New York*
54. Registrar's phone: *123-4567*
55. Registrar's signature: *John Doe*
56. Registrar's title: *Registrar*
57. Registrar's department: *Health Department*
58. Registrar's office: *City of New York*
59. Registrar's phone: *123-4567*
60. Registrar's signature: *John Doe*
61. Registrar's title: *Registrar*
62. Registrar's department: *Health Department*
63. Registrar's office: *City of New York*
64. Registrar's phone: *123-4567*
65. Registrar's signature: *John Doe*
66. Registrar's title: *Registrar*
67. Registrar's department: *Health Department*
68. Registrar's office: *City of New York*
69. Registrar's phone: *123-4567*
70. Registrar's signature: *John Doe*
71. Registrar's title: *Registrar*
72. Registrar's department: *Health Department*
73. Registrar's office: *City of New York*
74. Registrar's phone: *123-4567*
75. Registrar's signature: *John Doe*
76. Registrar's title: *Registrar*
77. Registrar's department: *Health Department*
78. Registrar's office: *City of New York*
79. Registrar's phone: *123-4567*
80. Registrar's signature: *John Doe*
81. Registrar's title: *Registrar*
82. Registrar's department: *Health Department*
83. Registrar's office: *City of New York*
84. Registrar's phone: *123-4567*
85. Registrar's signature: *John Doe*
86. Registrar's title: *Registrar*
87. Registrar's department: *Health Department*
88. Registrar's office: *City of New York*
89. Registrar's phone: *123-4567*
90. Registrar's signature: *John Doe*
91. Registrar's title: *Registrar*
92. Registrar's department: *Health Department*
93. Registrar's office: *City of New York*
94. Registrar's phone: *123-4567*
95. Registrar's signature: *John Doe*
96. Registrar's title: *Registrar*
97. Registrar's department: *Health Department*
98. Registrar's office: *City of New York*
99. Registrar's phone: *123-4567*
100. Registrar's signature: *John Doe*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page from the papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7774
CERTIFICATE OF DEATH

07750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yrl4mth2dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Byers Last McNeel		4. DATE OF DEATH Month July Day 1 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician		10b. KIND OF BUSINESS OR INDUSTRY Erco Co.	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Sanford Mc Neel		14. MOTHER'S MAIDEN NAME Ora Byers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month April Day 16 Year 1960 Hour 7 a. m. 1 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 16, 1960 to 7/1 , 19 60 , that I last saw the deceased alive on 7/1 , 19 60 , and that death occurred at 6:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED ACTUAL SIGNATURE Anthony S. Garofano M.D. PHYSICIAN'S NAME (Type) ANTHONY S. GAROFANO Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1960	
22c. NAME OF CEMETERY OR CREMATORY Geo Washington Cemetery - Hyattsville Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE JUL 5 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, NEW YORK

1914

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Date of death: _____
6. Place of death: _____
7. Cause of death: _____
8. Signature of physician: _____
9. Signature of registrar: _____
10. Date of registration: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
7775
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 12 FilmG267 7-29-60 et
CERTIFICATE OF DEATH

Reg. Dist. No. 07751

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6416 Frederick Ave.		d. STREET ADDRESS 6416 Frederick Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Megna Last Megna		4. DATE OF DEATH Month July Day 17 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29, 1872
9. AGE (In years last birthday) yrs. 88		IF UNDER 1 YEAR Months 12 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Sicily		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raphael Morgavi		14. MOTHER'S MAIDEN NAME Sara -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --	
INFORMANT Mrs. Stephen Provenza		Address 6416 Fred. Ave.	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Embolism DUE TO Pericarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post-operative hernia 6/19/48 DUE TO (c) 12 years		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/5 , 19 58 , to 7/17 , 19 60 that I last saw the deceased alive on 7/16 , 19 60 , and that death occurred at 6 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4123 Frederick Ave BALTO MD DATE SIGNED 7/20/60	
ACTUAL SIGNATURE James W. Katzenberger M.D.			
PHYSICIAN'S NAME (Type) JAMES W. KATZENBERGER		4123 FREDERICK AVE BALTO MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-21-60	
22c. NAME OF CEMETERY OR CREMATION Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home, Catonsville, Md.		24a. REC'D BY REGISTRAR DATE JUL 25 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

CENTRAL BANK OF AMERICA

1917

10

1

ПВС 57 П

CD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7777

CERTIFICATE OF DEATH

Reg. Dist. No.

07753

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 10 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrison Forest Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Emory Last Michael		4. DATE OF DEATH Month July Day 21 , Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1877
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George H. Michael		14. MOTHER'S MAIDEN NAME Mary C. Leonard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ella W. Michael		Address Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.-V. Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Portal Cirrhosis- Hernia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 5-20-40 , 19____, to 7-21-60 , 19____, that I last saw the deceased alive on 7-19-60 , 19____, and that death occurred at 7 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. Reisterstown, Md. DATE SIGNED 7-21-60			
ACTUAL SIGNATURE D. D. Caples		M.D. Reisterstown, Md.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		ADDRESS Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY St. Charles Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE JUL 25 '60		24b. REGISTRAR'S SIGNATURE C. L. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7683

CERTIFICATE OF DEATH

Reg. Dist. No. 07754

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5522 Delores Avenue				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First MARGARET M. Middle MILLER Last				4. DATE OF DEATH 7/28/60 Month Day Year			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/90	9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Family - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Arteriosclerotic Hypertensive CVD DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1/2 hr. ? yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1960 to July 28, 1960 that I last saw the deceased alive on July 28, 1960 , and that death occurred at 1:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5305 East Drive Baltimore DATE SIGNED 7/29/60							
ACTUAL SIGNATURE Herbert J. Levickas M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) B					
PHYSICIAN'S NAME (Type) Herbert J. Levickas		22b. DATE THEREOF 8/1/60		22c. NAME OF CEMETERY OR CREMATORY Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE McCully - I30 E. Fort Avenue				24a. REC'D BY REGISTRAR DATE AUG 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
77778
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
07755

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stonleigh</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armcast Nursing Home</i>		d. STREET ADDRESS <i>1815 Kingston Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>MARGARET A MITCHELL</i>		4. DATE OF DEATH <i>July 5 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 20, 1870</i>
9. AGE (In years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Upper Fairmount, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Sudler</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Waters</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mrs. J. Larkin Gorsuch.</i> Address <i>same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>450.0</i> DUE TO <i>Cardiac Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Arteriosclerosis</i> (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 10, 1950</i> to <i>July 5, 1960</i> that (I) <i>met</i> last saw the deceased alive on <i>July 5, 1960</i> and that death occurred on <i>July 5, 1960</i> at <i>3:10 A.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Laurence C. Post</i>		22b. DATE SIGNED <i>7/6/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>LAURENCE C. Post</i>		22d. ADDRESS <i>6805 York Rd. Baltimore 12 Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>July 8, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Presbyterian Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Pocomoke City Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins & Sons Co.</i>		25a. REC'D BY REGISTRAR <i>JUL 8 '60</i>	
ADDRESS <i>4905 York Road</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7779

CERTIFICATE OF DEATH

07756

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary(s) ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2mth16dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS none 18X-2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) William Lee Morgan				4. DATE OF DEATH Month July Day 11 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1895	
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.		IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph Morgan				14. MOTHER'S MAIDEN NAME Jeanette Burch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-32-5977			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 5, 19 60 to July 11, 19 60 that (I) (we) lost saw the deceased alive on July 11 19 60 , and that death occurred on July 11 19 60 , from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar				22b. DATE SIGNED 7-11-60			
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/14/60		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart		23d. LOCATION (City, town, or county) (State) Bushwood, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. Clark Mattingly, Leonard Town, Md.				25a. REC'D BY REGISTRAR DATE JUL 13 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

(M)

014

1

0

1

AP

CERTIFICATE OF DEATH

1918



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7780

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07757

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5103 Leeds Avenue				d. STREET ADDRESS 5103 Leeds Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret		First Margaret		Middle Mueller		Last	
4. DATE OF DEATH July 22, 1960		Month July		Day 22		Year 1960	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1891	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Keller				14. MOTHER'S MAIDEN NAME Francisca Fritch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-30-3893B		17. INFORMANT Address B Henry Mueller 5103 Leeds Avenue #27			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 hrs 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 24 1957 to July 22 1960 that (I) (we) lost saw the deceased alive on July 22 1960, and that death occurred at 6 A.M. from the causes and on the date stated above.							
22a. SIGNATURE A. Bradley				22b. DATE 7-22-60		22c. PHYSICIAN'S NAME (Type or print) A. Bradley	
22d. ADDRESS 1264 Francis Avenue				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS 1264 Francis Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/25/60		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR DATE JUL 25 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

67721

CERTIFICATE OF DEATH

1980



George Miller
2102 1/2 1st Street
St. Louis, Mo.
Born: [illegible]
Died: [illegible]
Cause of Death: [illegible]
Place of Death: [illegible]
Buried: [illegible]
Interment: [illegible]
Signature: [illegible]
Date: [illegible]

7781

CERTIFICATE OF DEATH

07758

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven N.H.		d. STREET ADDRESS 4202 Maryland Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle B. Last MULLER		4. DATE OF DEATH Month July Day 16 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1887
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner - Ret.		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick Strobel		14. MOTHER'S MAIDEN NAME Barbara Wengert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-18-6343	
INFORMANT Mrs. Alfred Strobel		Address 4202 Md. Place	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC CVD. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1/60 to 7/16/60 , that I last saw the deceased alive on 7/15/60 , and that death occurred at 7:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5800 E. MARYLAND AVE BALTO MD DATE SIGNED 7/18/60 ACTUAL SIGNATURE John H. Shaw M.D. PHYSICIAN'S NAME (Type) John H. Shaw M.D. DATE 28. MAR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-60	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park. Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home		24a. REC'D BY REGISTRAR DATE JUL 21 '60	
ADDRESS Catonsville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7781

(M)

(1)

NOT RECORDED

DECEASED

FILED

DECEASED

FILED

DECEASED

FILED

DECEASED

FILED

DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7782

CERTIFICATE OF DEATH

07759

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Rural</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armcoast Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia</u> First <u>Reid</u> Middle <u>MunnikhuySEN</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1876</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William C. Reid</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Thweatt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Miss Virginia MunnikhuySEN</u> Address <u>545 Cressy Road Bel Air, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, lower right.</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>C.V.A. left.</u> DUE TO (c) <u>Hypertensive arterio-sclerotic cardio-vascular disease.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>6/27/60</u> <u>4/15/60</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/15/60</u> , 19 <u> </u> , to <u>7/3/60</u> , 19 <u> </u> , that I last saw the deceased alive on <u>7/1/60</u> , 19 <u> </u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin B. Jaffett</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>11 East Chase St., Baltimore-2, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Edwin B. Jaffett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 5, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Spring Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rural Bel Air, Harford Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Brandon & Williams St. Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

LOCALITY OF DEATH		COUNTY	
BALTIMORE		BALTIMORE	
NAME OF DECEASED		SEX	
JAMES O. JAMES		M	
AGE		DATE OF BIRTH	
35		JAN 15 1900	
OCCUPATION		EDUCATION	
Carpenter		High School	
MARRIED		SINGLE	
MARITAL STATUS		DATE OF MARRIAGE	
Married		JAN 15 1925	
CAUSE OF DEATH		IMMEDIATE CAUSE	
Heart Disease		Myocardial Infarction	
PERIOD OF ILLNESS		DATE OF ONSET	
2 weeks		JAN 1 1935	
PLACE OF DEATH		DATE OF DEATH	
Home		JAN 15 1935	
TIME OF DEATH		HOUR	
10:00 AM		10:00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
J. O. JAMES		J. O. JAMES	
DATE		DATE	
JAN 15 1935		JAN 15 1935	

1. This is to certify that the above is a true and correct copy of the original as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 15th day of January, 1935.

2. This is to certify that the above is a true and correct copy of the original as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 15th day of January, 1935.

3. This is to certify that the above is a true and correct copy of the original as filed in the office of the Registrar of Deaths, Baltimore, Maryland, on the 15th day of January, 1935.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7783

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07760

Item 2 11164261 7-20-60 et

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Lancaster	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson/ Peach Bottom	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Presbyterian Home		d. STREET ADDRESS c/o C. E. Wiley	
3. NAME OF DECEASED (Type or print) Ella Wiley Murphy		4. DATE OF DEATH July 12 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Rankin Wiley		14. MOTHER'S MAIDEN NAME Alice B. Wells	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Presbyterian Home, Towson, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis - recurrant DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 332X			
INTERVAL BETWEEN ONSET AND DEATH 4 wks 3 years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from Jan. 1958 to July 12 1960 , that (I) (we) saw the deceased alive on July 6 1960 , and that death occurred at 6:20 am the causes and on the date stated above.			
22a. SIGNATURE S. J. Venable, Jr. M.D.		22b. DATE SIGNED July 13, 1960	
22c. PHYSICIAN'S NAME (Type) S. J. Venable, Jr. M.D.		22d. ADDRESS 7215 York Road, Baltimore 12, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-14-60	
23c. NAME OF CEMETERY OR CREMATORY West Nottingham Presbyterian		23d. LOCATION (City, town, or county) (State) Rising Sun, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		25a. REC'D BY REGISTRAR JUL 14 '60	
25b. REGISTRAR'S SIGNATURE Carlton L. Kraus			

M

090

1

107-60

MINISTRE DE LA JUSTICE

107-60



Document containing faint, mostly illegible text, possibly a letter or official communication. The text is mirrored and appears to be bleed-through from the reverse side of the page.



Document containing faint, mostly illegible text at the bottom of the page, likely bleed-through from the reverse side.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		0627-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice, Inc.				d. STREET ADDRESS 50 E. Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Margaret		Middle Murphy		Last Murphy	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month 7 Day 30th Year 1960	
9. AGE (In years lost birthday) 86 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) County Cork, Ireland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Unknown John Ryan		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Rev. John J. Murphy		Address Baltimore, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Renal DUE TO (c) Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 12 MRS 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 1960		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1958 to July 30, 1960 that (I) (we) lost the deceased alive on July 30, 1960 and that death occurred on July 30, 1960 from the causes on and on the date stated above.							
22a. SIGNATURE Charles F. O'Donnell				22b. DATE SIGNED July 30, 1960		22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell- M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8-4-60		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.		23d. LOCATION (City, town, or county) (State) Amesbury, Mass.	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				25a. REC'D BY REGISTRAR DATE AUG 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

CERTIFICATE OF DEATH

7784



7785

CERTIFICATE OF DEATH

Reg. Dist. No.

07762

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>618 Ralston Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>618 Ralston Ave.</u>		d. STREET ADDRESS <u>618 Ralston Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Clifton</u> First <u>Sylvester</u> Middle <u>Myers</u> Last		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 14, 1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u> Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltio. City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Myers</u>		14. MOTHER'S MAIDEN NAME <u>Julia Butler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-30-5497</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of Aortic Aneurysm</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>9</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/5/60</u> , 19 <u>60</u> , to <u>7/9/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/9/60</u> , 19 <u>60</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>6410 Annapolis Mill Rd Baltimore Md</u> DATE SIGNED <u>Belto 7/9/60</u>	
ACTUAL SIGNATURE <u>Milton Schleier</u>		M.D. <u>6410 Annapolis Mill Rd Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>Milton Schleier MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 12, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Linganore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell</u>		24a. REC'D BY REGISTRAR <u>JUL 13 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton S. Thomas</u>			

07763

7786

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		Md.		b. COUNTY		BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural		Reisterstown		c. LENGTH OF STAY IN 1b		X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Reisterstown, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Md.		600 Beverley Rd., Reisterstown		d. STREET ADDRESS		600 Beverly Road,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year	
Ira		Robert		Myers Jr.		July		9,		19		60			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		March 1, 1933		27		Months		Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
Policemen		Baltimore Co.		Maryland		U.S.A.									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
Ira Robert Myers Sr.		Etta Virginia Wiley													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Reisterstown, Md.									
No		None		216-30-8655		Mrs. Margaret F. Myers, 600 Beverly Rd.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 4 months											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I attended the deceased from April 1960, to July 9, 1960 that I last saw the deceased alive on July 9, 1960, and that death occurred at 6:45 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED											
ACTUAL SIGNATURE		Clarence E. McWilliams M.D.		11904 Reisterstown Rd., Reisters											
PHYSICIAN'S NAME (Type)		Clarence E. McWilliams M.D.		11904 Reisterstown Rd., Reisters											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)							
Burial		July 13, 1960		Druid Ridge Cemetery		Pikesville 8, Md.									
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE											
Frank A. Newell Pikesville		JUL 18 '60		Arthur S. Krawa											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

VS AIS (4)
ISM 9/58

RECORDS OF DEATHS

1788

4

7673
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1825 Walnut Ave., # 22				d. STREET ADDRESS 1825 Walnut Ave., #22.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEONARD JOSEPH NARDONE				4. DATE OF DEATH Month July Day 23 Year 1960.			
5. SEX M ale		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 23, 1877	
9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME John Nardone				14. MOTHER'S MAIDEN NAME Grace Bishi			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Antoinette A. Nardone		Address Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 150X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 July, 1960 , to 24 July, 1960 , that I last saw the deceased alive on 24 July, 1960 , and that death occurred at 2:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.H. Morrison				ADDRESS (Street, city or town, state) 3 Kinship Rd. Dundalk, Md.			
PHYSICIAN'S NAME (Type) W.H. Morrison				DATE SIGNED Jul 26 '60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-60.		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler				ADDRESS 901 S. CONKLING ST. BALTO., MD.		24a. REC'D BY REGISTRAR Jul 26 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Year, Day, etc.

NAME OF DECEASED
SEX
AGE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

PERMANENT CAUSE

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7787
CERTIFICATE OF DEATH
07765

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY matthew	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		d. STREET ADDRESS Grab Road	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM FREDERICK NEALE, SR.		4. DATE OF DEATH Month Day Year July 10, 1960 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-retired		10b. KIND OF BUSINESS OR INDUSTRY Wholesale Foods	
11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William F. Neale		14. MOTHER'S MAIDEN NAME Elizabeth Hedges	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wm. F. Neale, Jr. Pottspring Rd., Timonium, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Cerebral vascular accident.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1959 to 7/10 , 19 60 , that (I) (we) last saw the deceased alive on 7/11 , 19 60 , and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Samuel Stern, M.D.		22b. DATE SIGNED 7/11/60	
22c. PHYSICIAN'S NAME (Type) SAMUEL STERN		22d. ADDRESS 1010 E. Belvidere Av.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 13, 1960	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City, town, or county) (State) Parkville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		25a. REC'D BY REGISTRAR JUL 13 1960	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

CERTIFICATE OF DEATH

Washington, Maryland

John, son of John and Mary

born July 10, 1900

July 10, 1900

White male

Single - never married

William F. Heale

Heale, William F., 1000 1/2 St., N.W., Washington, D.C.

John, son of John and Mary

born July 10, 1900

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7788
CERTIFICATE OF DEATH

07766
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Chapel Hill Con. Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Margaret Anna Newnam</i>		4. DATE OF DEATH Month Day Year <i>July 16th 19 60</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 18, 1883</i>
9. AGE (In years lost birthday) <i>76</i> yrs.		10. BIRTHPLACE (State or foreign country) <i>Cumberland, Maryland</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Laibel</i>		14. MOTHER'S MAIDEN NAME <i>Lena Schmidt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <i>Informant</i> Address <i>Mrs. Rosalia T. Good 1613 Orlando Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar pneumonia</i> 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>Hepatic failure</i> DUE TO (c) <i>ASCVD.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Possible carcinoma of liver</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 9</i> , 19 <i>60</i> , to <i>July 16</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>June 14</i> , 19 <i>60</i> , and that death occurred at <i>9:30</i> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>John J. Darrell</i> M.D.			
PHYSICIAN'S NAME (Type) <i>JOHN J. DARRELL, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/1 19/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Peter and Paul</i>		22d. LOCATION (City, town, or county) (State) <i>Cumberland, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road.</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 18 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

STATE OF CALIFORNIA
COUNTY OF LOS ANGELES
I, the undersigned, County Clerk of said County, do hereby certify that the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of said County.

Witness my hand and the seal of said County at Los Angeles, California, this _____ day of _____, 19____.

County Clerk

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

M

2
MEDICAL CERTIFICATION

2

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
7789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07767									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 12					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 12				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6807 Bellona Avenue					d. STREET ADDRESS 6807 Bellona Avenue				
3. NAME OF DECEASED (Type or print) MABEL G. NICHOLS					4. DATE OF DEATH July 26 19 60				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 2, 1893		9. AGE (In years last birthday) 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) secretary		10b. KIND OF BUSINESS OR INDUSTRY Bukert Terminals Corporation		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME James. Nichols					14. MOTHER'S MAIDEN NAME Gertrude Rothrock				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-01-1562		17. INFORMANT Warren E. Nichols, 1226 St. Paul Street					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial		20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Petty		EXAMINER'S NAME (Type) Charles S. Petty, M.D.		M.D. _____		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) _____		DATE SIGNED 7/26/60					
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF 7-28-60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or country) Baltimore		(State) _____	
23. FUNERAL DIRECTOR William Cook, Inc., 1217 St. Paul Street				ADDRESS _____		24a. REC'D BY REGISTRAR JUL 29 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



FOR SALE
BY THE

Baltimore

Baltimore 12

6807 Columbia Avenue

MAR 21

G.

WISCONSIN

July 29

W 80

Baltimore 12

6807 Baltimore Avenue

November 2, 1992

White

James E. Nichols

Secretary

Maryland

U.S.A.

Gertrude Kottgrosch

James E. Nichols

217-01-1562 James E. Nichols, 1236 St. Paul Street

Anteriorly located cardiovascular system.

United

X

Charles E. Nichols, M.D.

7-28-50

RECEIVED

London Park Cemetery

Baltimore

William Cook, Inc., 1012 St. Paul Street

July 29

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7674

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07768

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNA. b. COUNTY 75X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reading, Pennsylvania	
c. LENGTH OF STAY IN 1b 3 mos 23 day		d. STREET ADDRESS 528 N. 2nd Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BROOKING HWY - NR. DUNDALK AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS First TACVZER Middle Noecker Last		4. DATE OF DEATH JULY Month 4 Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1928
9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME (Last name) Earl J. J. Foster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1948 - death		16. SOCIAL SECURITY NO. 204-22-2963	
17. INFORMANT Service Records @ Ft. Holabird, Md.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound Fracture of SKULL 819X DUE TO Conditions, if any, which gave rise to immediate cause (b) CRUSHED CHEST (a), stating the underlying cause lost. DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) RAN Auto onto Bridge + turned over	
20c. TIME OF INJURY Month, Day, Year 7-4-60	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bridge	20f. (City or town) DUNDALK - BALTO MD (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF, MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7/7/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7/7/60	
22c. NAME OF CEMETERY OR CREMATORY Henninger Funeral Home		22d. LOCATION (City, town, or county) Reading, Pennsylvania (State) 	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Hamilton		24a. REC'D BY REGISTRAR Aug 2 '60	
ADDRESS 6306 - Belair Rd, Baltimore - 6, Md		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7790 CERTIFICATE OF DEATH 07769

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Randallstown</u>				c. LENGTH OF STAY IN lb <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marriottsville Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Lee</u> Last <u>Odell</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 28, 1875</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Henry Ehlers</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Holbrook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-32-1973</u>			
17. INFORMANT <u>Ruth O. Enos</u>				Address <u>Randallstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of uterus</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardio-vascular disease</u>							
INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>7/20/1960</u> that (I) (we) last saw the deceased alive on <u>7/20/1960</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. E. Martin</u>				22b. DATE SIGNED <u>1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>				22d. ADDRESS <u>RANDALLSTOWN Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>7/22/60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Paran Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Randallstown, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Luther S. Knight</u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>JUL 25 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

CERTIFICATE OF DEATH

M

1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
7791

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07770

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. LENGTH OF STAY IN 1b <u>Woodlawn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2702 Gwynnmore Ave.</u>				d. STREET ADDRESS <u>2702 Gwynnmore Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Glenna</u> Middle <u>Davis</u> Last <u>Paxton</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> , Year <u>60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1876</u>		9. AGE (In years last birthday) <u>83</u> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>Henry Davis</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Minor</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Mr. R. Irving Paxton - 4038 The Alameda</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u>10 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>*****</u>			
20c. TIME OF INJURY Hour o. m. <u>***</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>*****</u>	
20f. (City or town) <u>*****</u>				20g. (County) (State)			
21. I certify that (I) <u>Millard T. Traband, Jr.</u> attended the deceased from <u>February 1960</u> to <u>7/11 1960</u> , that (I) (we) last saw the deceased alive on <u>July 11, 1960</u> , and that death occurred at <u>6:30 A.M.</u> the causes and on the date stated above.							
22a. SIGNATURE <u>Millard T. Traband, Jr.</u>				22b. DATE SIGNED <u>7/13/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Millard T. Traband, Jr. M. D.</u>	
22d. ADDRESS <u>5101 Gwynn Oak Ave. Baltimore, 7, Md.</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> MED. STAFF <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/14/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>		23d. LOCATION (City, town, or county) (State) <u>Elkridge, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Dickner & Sons - Balto.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Evans</u>	

CERTIFICATE OF DEATH

7791

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

10. 10. 1910

MEDICAL CERTIFICATION

VS A1S (4)
ISM 9/SB

1958

WASHINGTON

(M)

AMERICAN NATIONAL 6 points

1010 Kilmuir Ave., Baltimore, Md.

July 2

1010 Kilmuir Ave., Baltimore, Md.

USA

Michael

1010 Kilmuir Ave., Baltimore, Md.

(1)

1010 Kilmuir Ave., Baltimore, Md.

1010 Kilmuir Ave., Baltimore, Md.

TO DEED: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

Item 18 Film 268 7-25-60										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07772																													
7793										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.																													
1. PLACE OF DEATH a. COUNTY Baltimore					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					c. LENGTH OF STAY IN 1b 2mth5dys					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					b. COUNTY Baltimore					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore County - Catonsville					d. STREET ADDRESS 11 Wade Avenue					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First Oscar Middle H Last Pulliam					4. DATE OF DEATH Month July Day 8 Year 1960					5. SEX male					6. COLOR OR RACE white					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH May 18, 1887					9. AGE (In years last birthday) 73 yrs.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown					11. BIRTHPLACE (State or foreign country) Virginia					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Lucietta Gerring					15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown					16. SOCIAL SECURITY NO. 219-10-6854					17. INFORMANT Records: SPRING GROVE STATE HOSPITAL					Address																								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO 904.7 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 904.7 (b) Broncho Pneumonia Pneumonia (c) Fracture of right hip (femur) Accident										INTERVAL BETWEEN ONSET AND DEATH																																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. was found with intertrochanteric frac. of rt. femur - do not know the exact reason for this.					20c. TIME OF INJURY Month, Day, Year 12:15 p.m. 5-26 1960					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital					20f. (City or town) Catonsville 28, Maryland					(County) (State)																			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF 7/11/60					22c. NAME OF CEMETERY OR CREMATORY Torraim					22d. LOCATION (City, town, or county) (State) Baltimore Co. Md.																			
23. FUNERAL DIRECTOR'S SIGNATURE George M. Kieffer, M. D.										24a. REC'D BY REGISTRAR JUL 11 '60										24b. REGISTRAR'S SIGNATURE Julius S. Frank										DATE JUL 11 '60																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician only. Pages 3 and 4 should be filled with the information required by the funeral director. After this certificate has been signed by the attending physician only, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and retain them for use as the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7794
77773
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7402 Knollwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WASHINGTON ROBY PURNELL		4. DATE OF DEATH JULY 24 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 12, 1902
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ART DEALER		10b. KIND OF BUSINESS OR INDUSTRY Purnell Art Galleries	
11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WASHINGTON ROBY PURNELL, sr.		14. MOTHER'S MAIDEN NAME NORA NORTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-32-6779	
17. INFORMANT MRS PURNELL		Address JANE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) HYPERTENSION DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET OF DEATH 2-3 YRS 20-30 YRS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/20 19 60 to 7/24 19 60 , that (I) (we) last saw the deceased alive on 7/24 19 60 , and that death occurred at 5 AM , from the causes and on the date stated above.			
22a. SIGNATURE George J. Bunke		22b. DATE SIGNED 7/24/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 301 E UNIVERSITY PKY	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/60	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Pikesville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ann J. T. [Signature]		25a. REC'D BY REGISTRAR JUL 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]		25c. ADDRESS BALTO - 17, Md.	

ATTN

CERTIFICATE OF DEATH

1944

DATE

1944

1944

W

1

1944

1944

1944

1944

1944

1944

1944

1944

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
BM 2/57

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7795 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07774

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex (21)</u>		c. LENGTH OF STAY IN 1b <u>54</u> <u>Essex (21)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1604 Rickenbacker Rd.</u>		d. STREET ADDRESS <u>1604 Rickenbacker Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ESTELLA C. (HARTMAN) QUILLIN</u>		4. DATE OF DEATH Month Day Year <u>July 7 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1896</u>
9. AGE (in years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hennan</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-03-0805D</u>	
17. INFORMANT <u>Andrew Hartnan</u>		Address <u>1804 Middleborough Rd. #21</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-DISEASE</u> <u>422.1</u> DUE TO (b) <u>DIABETES MELLITUS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____ _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/8/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/9/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Bruzdinski</u>		ADDRESS <u>1407 Eastern Ave.</u>	
24a. REC'D BY REGISTRAR <u>JUL 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7796

CERTIFICATE OF DEATH

Reg. Dist. No.

07775

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 21 E. Joppa Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u> d. STREET ADDRESS <u>Box 21 E. Joppa Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Nellie</u> <u>G.</u> <u>Reed</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 26, 1884</u> 9. AGE (In years lost birthday) <u>76</u> yrs.				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1960</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> 11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Walter C. Gambrill</u> 14. MOTHER'S MAIDEN NAME <u>Imogene Owens</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mr. David H. Reed Sr.</u> Address <u>Box 21 E. Joppa Rd.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO (b) <u>coronary thrombosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>420MI</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetis mellitus</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 18, 1958</u> to <u>July 12, 1960</u> , that I last saw the deceased alive on <u>July 12, 1960</u> , and that death occurred at <u>8:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9660 Belair Rd. Balto 6, Md.</u> DATE SIGNED <u>7/13/60</u> ACTUAL SIGNATURE <u>Theodore E. Evans, M.D.</u>								22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7-16-1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Camp Chapel Methodist</u> 22d. LOCATION (City, town, or county) (State) <u>Joppa Rd. Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cassady Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

STATE OF NEW YORK

1918

Blank form for Certificate of Death with various fields for registration.

M

1

7707

CENTINCA E OF LEATH

MAINTENANCE OF HEALTH

Salto

Isabelle

2110 F. L. H. Road

Georgia

William

William

Feb. 2, 1930

Swedish

Polynesian

Elizabeth Jones

George William

St. 10-2025

W. D. William William 6211 Hoxworth Road

St. John L. H. Road

6204 Hoxworth Road, Salto, I. H.

7-8-10

St. John L. H. Road

St. John L. H. Road

St. John L. H. Road

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7798

CERTIFICATE OF DEATH

07777

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>329 Harlem Lane</u>				c. LENGTH OF STAY IN 1b <u>1 wk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frederick</u> First Middle Last <u>W. Reter</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 3, 1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Reter</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Lins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-2391</u>		17. INFORMANT <u>Mrs. Mary E. Reter</u>		Address <u>Reisterstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Acute Urinary Retention</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/6</u> 19 <u>60</u> to <u>7/13</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>6/12</u> 19 <u>60</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Cliff Ratliff Jr.</u>				22b. DATE SIGNED <u>7/15/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, JR.</u>				22d. ADDRESS <u>4605 EDMONDSON AVE</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/16/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Lutheran</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline & Sons</u>				ADDRESS <u>Reisterstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 18 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>			

Balto 29

CERTIFICATE OF DEATH

1938

(M)

(1)

Signature of Registrar

Place of Death

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be removed from the certificate. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7799 **CERTIFICATE OF DEATH** 07778

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7yr6mth5dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Clermont Last Rivers				4. DATE OF DEATH Month July Day 19 Year 1960			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1877	
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 19 Days 19 Hours 60 Min.		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) woodwork				10b. KIND OF BUSINESS OR INDUSTRY Knob Co.			
13. FATHER'S NAME Augustus H. Rivers				14. MOTHER'S MAIDEN NAME Elizabeth Stevenson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 213-09-9858		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis with effusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 002X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) old Cerebral vascular accident - Generalized arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 12, 1960 to July 19, 1960 , that (I) (we) last saw the deceased alive on July 19, 1960 , and that death occurred at 7:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachsler				22b. DATE SIGNED 7-19-60			
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		7/22/60		New Cathedral Cem.		4300 Old Fox Louck Rd.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Brownson				25a. REC'D BY REGISTRAR HUL 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

M

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

7800

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07779

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7907 Stevenson Road</u>				d. STREET ADDRESS <u>17907 Stevenson Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ellen</u> First <u>RIZIKA</u> Middle <u>ANNA</u> Last <u>ANNA</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 7, 1948</u>	
9. AGE (In years last birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.		IF UNDER 24 HRS. Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr. Stuart Rizicka</u>				14. MOTHER'S MAIDEN NAME <u>Beverly Weiner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Dr. Stuart Rizicka</u> Address <u>7907 Stevenson Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lympho Sarcoma of Bladder</u> <u>200.1</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>February</u> , 19 <u>60</u> , to <u>July</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>July 18</u> , 19 <u>60</u> , and that death occurred at <u>3:20</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>John A. Askin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>John A. Askin</u>				22d. ADDRESS <u>1401 Reisterstown Road Baltimore</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Chick Adams</u>		23d. LOCATION (City, town, or county) <u>Baltimore, Md</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Johnson</u> ADDRESS <u>600 Reisterstown</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>JUL 20 '60</u>							

CERTIFICATE OF DEATH

1907

(M)

1907
1907
1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

1907

7801

CERTIFICATE OF DEATH

Reg. Dist. No.

07780

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULLERTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULLERTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4502 FORGE RD. #6, MD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last FRANCES C. ROHE				4. DATE OF DEATH Month Day Year JULY 9 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 26, 1888		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK VANIK				14. MOTHER'S MAIDEN NAME JOSEPHINE UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 210-26-2706		INFORMANT STANLEY REIDER		Address 4502 FORGE RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Coronary arteriosclerosis DUE TO (c) Arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 2 hours 4 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized osteoarthritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-17 , 19 59 , to 5-22 , 19 60 , that I last saw the deceased alive on 5-22 , 19 60 , and that death occurred at 12:50 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Santi Amoroso				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 12, 1960		22c. NAME OF CEMETERY OR CREMATORY ST JOSEPHS. CEM.		22d. LOCATION (City, town, or county) (State) BALTIMORE CO MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Sasseln Funeral Home				24a. REC'D BY REGISTRAR 7401 Belair Rd		24b. REGISTRAR'S SIGNATURE Charles J. Hines	

TO HOSTS: OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7802

CERTIFICATE OF DEATH

Reg. Dist. No. 07781

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN lb 52 Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Rosewood Ave.				d. STREET ADDRESS 106 Rosewood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Harriet		Middle B.		Last Rowe	
4. DATE OF DEATH		Month July		Day 16		Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1887		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William T. Barker				14. MOTHER'S MAIDEN NAME Ida E. Brohann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----		INFORMANT Address Mr. John I. Rowe 106 Rosewood Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic hypertensive cardiovascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 months or less 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19 7-16 , 19 60 , that I last saw the deceased alive on 23 June , 19 60 , and that death occurred at 4A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1118 St Paul St, Baltimore 2, Maryland DATE SIGNED							
ACTUAL SIGNATURE John A. Nesbitt, Jr.		M.D. 1118 St Paul St, Baltimore 2, Maryland					
PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-60		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home., Catonsville, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 21 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO PRESS

587

100

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/59

1473

CERTIFICATE OF DEATH

1908

WILLIAM

WILLIAM

MINISTERS

1908

FOUR INWARD

CHURCH OF ENGLAND

WILLIAM J. ALMOND

BOY

JOHN

1908

1908

U.S.A.

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

1908

7675

CERTIFICATE OF DEATH

07783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6729 RAILWAY AVE. #22		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANDREW Middle J. Last SANDERS		4. DATE OF DEATH Month JULY Day 21 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 13, 1900
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WEIGHER	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN SANDERS	
14. MOTHER'S MAIDEN NAME KATHERINE KAUFMAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NO		17. INFORMANT MARIE H. SANDERS Address SAME.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.1 Gastroenteritis acute & Hemorrhagic Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) 1 week (c) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 20, 1960 to July 21, 1960 , that I last saw the deceased alive on July 21, 1960 , and that death occurred at 1:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6714 HOLABIRD AVE Baltimore Md 7-2260 DATE SIGNED 7-22-60			
ACTUAL SIGNATURE Stephen C. Mackowiak		PHYSICIAN'S NAME (Type) S. C. MACKOWIAK	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7-23-60	
22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		22d. LOCATION (City, town, or county) (State) 7225 EASTERN BLVD., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler ADDRESS 901 S. CONKLING ST. BALTO., MD.		24a. REC'D BY REGISTRAR DATE JUL 25 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Krause			

Page 1 after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and in any event within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and in any event within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and in any event within 72 hours after death.

14

1932

CENTRAL AIR LINE

BALTIMORE

MD.

BALTIMORE

CONRAD

CONRAD

612 BALTIMORE AVENUE

612 BALTIMORE AVENUE

INDUSTRIAL

INDUSTRIAL

INDUSTRIAL

MAR 1932

MAR 1932

MAR 1932

INDUSTRIAL

INDUSTRIAL

INDUSTRIAL

INDUSTRIAL

MAR 1932

MAR 1932

INDUSTRIAL

INDUSTRIAL

INDUSTRIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VR A15 (4)
15M 9/59

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

7804

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07784

Item 14 Film G267 7/15/60 1wk

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 BLENHEIM ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDITH First A. Middle Sauer Last SAUER		4. DATE OF DEATH July 8 19 60 Month July Day 8 Year 19 60	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-1901
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES WATT		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MR. GEORGE F. SAUER SR. Address 215 BLENHEIM RD BALT 12, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinomatosis DUE TO 153-3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Melastatic carcinoma right femur DUE TO Adeno carcinoma sigmoid colon (c) Adeno carcinoma sigmoid colon		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 22 Nov 1957 to 6 July 1960 , that (I) (we) last saw the deceased alive on 7 July 1960 , and that death occurred at 7:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE John W Barnaby		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN W BARNABY		22d. ADDRESS 1531 E North Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		23b. DATE THEREOF JULY 11, 1960	
23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) BALTIMORE COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE HENRY W. JENKINS & SONS Co		25a. REC'D BY REGISTRAR DATE 8-12-60	
ADDRESS 4905 YORK RD. BALT 12.		25b. REGISTRAR'S SIGNATURE Robert E. Hines	

CERTIFICATE OF DEATH

1804

00772

1

1

MADE IN U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7805

CERTIFICATE OF DEATH

07785
 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3800 Taylor Avenue n</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mr. John Albert Schafer</i>		4. DATE OF DEATH Month <i>July</i> Day <i>19</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 27, 1878</i>
9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Carpenter</i>	
11. BIRTHPLACE (State or foreign country) <i>Hartford Co. Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Schafer</i>		14. MOTHER'S MAIDEN NAME <i>Ellen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Informant</i> Address <i>Mrs. Anna B. Schafer 3800 Taylor Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic C.V.D.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary thrombotic episodes</i> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1950</i> to <i>July 15</i> , 1960, that I last saw the deceased alive on <i>June 10</i> , 1960, and that death occurred at <i>1 P. M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>J. Henry Haase M.D.</i> M.D. <i>2926 E. Cold Spring Lane</i> PHYSICIAN'S NAME (Type) <i>J. Henry Haase M.D.</i> <i>Baltimore, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/22/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Hartford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>JUL 21 '60</i>	24b. REGISTRAR'S SIGNATURE <i>William E. Haase</i>

525

فلا تفرحوا

1131455

15109075

2022

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7806

CERTIFICATE OF DEATH

Reg. Dist. **12786**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 6 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Jane Last Schanberger		4. DATE OF DEATH Month 7 Day 21 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR: Months 4 Days 21 Hours 01 Min. 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Roston		14. MOTHER'S MAIDEN NAME Mary Jane Cooney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Renal Vascular Disease DUE TO (c) 16 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1955 to July 21, 1960 that I last saw the deceased alive on July 20, 1960 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7/21/60	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell- M.D.		DATE/SIGNED 7/21/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-23-60	22b. DATE THEREOF 7-23-60	22c. NAME OF CEMETERY OR CREMATORY New Cathedral	22d. LOCATION (City, town or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Luck ADDRESS 5305 Bayford		24a. REC'D BY REGISTRAR JUL 22 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE-18

7807

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07787

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 18 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RALPH Middle M. Last SCHAPIRO				4. DATE OF DEATH Month JULY Day 8 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 3, 1891	
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAIL CARRIER (RETIRED)		11. BIRTHPLACE (State or foreign country) U.S. POSTAL SERVICE BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SOLOMON I. SCHAPIRO				14. MOTHER'S MAIDEN NAME IDA ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1 217-40-3002		17. INFORMANT CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASTROCYTOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 20, 1960 , to JULY 8, 1960 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JULY 8, 1960 , and that death occurred at 5:35 p.m. from the causes and on the date stated above.							
22a. SIGNATURE <i>Philip J. Jensen</i>				22b. DATE SIGNED 7-8-60		22c. PHYSICIAN'S NAME (Type) PHILIP J. JENSEN	
22d. ADDRESS M.S. VAH BALTIMORE 18 MD-FT HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/10/60		23c. NAME OF CEMETERY OR CREMATORY BOBROISKER BENEFICIAL CIRCLE CEMETERY		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE SoL LEVINSON & BROS INC				25a. REC'D BY REGISTRAR DATE JUL 12 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

3807

11/18/58

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

NAME OF DECEASED

DATE OF INTERVIEW

NAME OF INTERVIEWER

REMARKS

DATE OF INTERVIEW

NAME OF INTERVIEWER

NAME OF DECEASED

DATE OF INTERVIEW

NAME OF INTERVIEWER

NAME OF DECEASED

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
7808 Film 6268 8-4-60 et 07788											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Balt					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore-Rural						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 6					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Martin Span						d. STREET ADDRESS 50 Hawthorne Road					
3. NAME OF DECEASED (Type or print) First JOSEPH Middle GEORGE Last SELESKY						4. DATE OF DEATH Month July Day 27 Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 3, 1939		9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months 21 Days 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter						10b. KIND OF BUSINESS OR INDUSTRY Md. Match Co.		11. BIRTHPLACE (State or foreign country) Allison, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph George Selesky						14. MOTHER'S MAIDEN NAME Grace Newcomer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. U.S.A.R.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple fractures of skull, trunk and extremities 812X XXXXX with massive internal injuries and hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						20. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto in auto-truck collision, thrown out of car and run over by another car					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						22. TIME OF INJURY Month, Day, Year 7/27, 1960 Hour a.m. 6:43 xx					
23. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road					
25. TIME OF INJURY Month, Day, Year 7/27, 1960 Hour a.m. 6:43 xx						26. (City or town) (County) (State) Baltimore Md.					
27. ACTUAL SIGNATURE W. Bradley King, Jr.						28. DATE SIGNED 7/27/60					
29. EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.						30. ADDRESS (Street, city, town, or county) 1217 St. Paul St. Baltimore Md.					
31. BURIAL, CREMATION, REMOVAL (Specify) 7-28-60						32. NAME OF CEMETERY OR CREMATORY Lafayette Memorial Pk. Brier Hall, Pa.					
33. FUNERAL DIRECTOR Wm Cook Funeral Home						34. REC'D BY REGISTRAR AUG 1 '60					
35. REGISTRAR'S SIGNATURE Charles E. King						36. REGISTRAR'S SIGNATURE Charles E. King					

100-100000
100-100000

(M)

(1)

0-10

5808

England

Belgium

30 September 1940

London

100-100000

only

Belgium

Belgium

Belgium

White

...with active ...
...of ...

...of ...
...of ...

...
...
...

100-100000

...
...

100-100000

7676

CERTIFICATE OF DEATH

Reg. Dist. No. 07789

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>03 North Carolina</u> b. COUNTY <u>Halifax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Halifax</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>123 Cypress St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>Shearin</u> Last <u>Shearin</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 15, 1865</u>	9. AGE (In years last birthday) <u>95</u> yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>7</u> Hours <u>7</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sanitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Court House</u>		11. BIRTHPLACE (State or foreign country) <u>Warren, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Simon Pugh</u>				14. MOTHER'S MAIDEN NAME <u>Susan ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT <u>Susie Leak</u> Address <u>1125 N. Strickland St, Baltimore, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>593X</u> DUE TO (b) <u>Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Pneumonia & Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 hrs</u> <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month. Day. Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>51</u> , to <u>July 22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 22</u> , 19 <u>60</u> , and that death occurred at <u>8:00</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>40 Oak Ave.</u> DATE SIGNED <u>July 22, 1960</u>							
ACTUAL SIGNATURE <u>William C. Wade</u> M.D.				PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u> <u>Dundalk 22, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>Burial</u>	<u>7-26-60</u>	<u>New Cemetery</u>		<u>Halifax, N. C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Jackson</u> ADDRESS <u>Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1945</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. MEDICAL HISTORY <i>None</i>	
10. OCCUPATION <i>Engineer</i>		11. EDUCATION <i>High School</i>		12. RELIGION <i>Catholic</i>	
13. MARITAL STATUS <i>Married</i>		14. NUMBER OF CHILDREN <i>3</i>		15. PRESENT ADDRESS <i>123 Main St, Baltimore, Md.</i>	
16. DATE OF BIRTH <i>Jan 15 1900</i>		17. PLACE OF BIRTH <i>St. Louis, Mo.</i>		18. DATE OF ENTRY INTO STATE <i>1910</i>	
19. DATE OF DEPARTURE FROM STATE <i>None</i>		20. DATE OF RETURN TO STATE <i>None</i>		21. DATE OF DEPARTURE FROM COUNTRY <i>None</i>	
22. DATE OF RETURN TO COUNTRY <i>None</i>		23. DATE OF DEPARTURE FROM STATE <i>None</i>		24. DATE OF RETURN TO STATE <i>None</i>	
25. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		26. DATE OF RETURN TO COUNTRY <i>None</i>		27. DATE OF DEPARTURE FROM STATE <i>None</i>	
28. DATE OF RETURN TO STATE <i>None</i>		29. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		30. DATE OF RETURN TO COUNTRY <i>None</i>	
31. DATE OF DEPARTURE FROM STATE <i>None</i>		32. DATE OF RETURN TO STATE <i>None</i>		33. DATE OF DEPARTURE FROM COUNTRY <i>None</i>	
34. DATE OF RETURN TO COUNTRY <i>None</i>		35. DATE OF DEPARTURE FROM STATE <i>None</i>		36. DATE OF RETURN TO STATE <i>None</i>	
37. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		38. DATE OF RETURN TO COUNTRY <i>None</i>		39. DATE OF DEPARTURE FROM STATE <i>None</i>	
40. DATE OF RETURN TO STATE <i>None</i>		41. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		42. DATE OF RETURN TO COUNTRY <i>None</i>	
43. DATE OF DEPARTURE FROM STATE <i>None</i>		44. DATE OF RETURN TO STATE <i>None</i>		45. DATE OF DEPARTURE FROM COUNTRY <i>None</i>	
46. DATE OF RETURN TO COUNTRY <i>None</i>		47. DATE OF DEPARTURE FROM STATE <i>None</i>		48. DATE OF RETURN TO STATE <i>None</i>	
49. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		50. DATE OF RETURN TO COUNTRY <i>None</i>		51. DATE OF DEPARTURE FROM STATE <i>None</i>	
52. DATE OF RETURN TO STATE <i>None</i>		53. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		54. DATE OF RETURN TO COUNTRY <i>None</i>	
55. DATE OF DEPARTURE FROM STATE <i>None</i>		56. DATE OF RETURN TO STATE <i>None</i>		57. DATE OF DEPARTURE FROM COUNTRY <i>None</i>	
58. DATE OF RETURN TO COUNTRY <i>None</i>		59. DATE OF DEPARTURE FROM STATE <i>None</i>		60. DATE OF RETURN TO STATE <i>None</i>	
61. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		62. DATE OF RETURN TO COUNTRY <i>None</i>		63. DATE OF DEPARTURE FROM STATE <i>None</i>	
64. DATE OF RETURN TO STATE <i>None</i>		65. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		66. DATE OF RETURN TO COUNTRY <i>None</i>	
67. DATE OF DEPARTURE FROM STATE <i>None</i>		68. DATE OF RETURN TO STATE <i>None</i>		69. DATE OF DEPARTURE FROM COUNTRY <i>None</i>	
70. DATE OF RETURN TO COUNTRY <i>None</i>		71. DATE OF DEPARTURE FROM STATE <i>None</i>		72. DATE OF RETURN TO STATE <i>None</i>	
73. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		74. DATE OF RETURN TO COUNTRY <i>None</i>		75. DATE OF DEPARTURE FROM STATE <i>None</i>	
76. DATE OF RETURN TO STATE <i>None</i>		77. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		78. DATE OF RETURN TO COUNTRY <i>None</i>	
79. DATE OF DEPARTURE FROM STATE <i>None</i>		80. DATE OF RETURN TO STATE <i>None</i>		81. DATE OF DEPARTURE FROM COUNTRY <i>None</i>	
82. DATE OF RETURN TO COUNTRY <i>None</i>		83. DATE OF DEPARTURE FROM STATE <i>None</i>		84. DATE OF RETURN TO STATE <i>None</i>	
85. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		86. DATE OF RETURN TO COUNTRY <i>None</i>		87. DATE OF DEPARTURE FROM STATE <i>None</i>	
88. DATE OF RETURN TO STATE <i>None</i>		89. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		90. DATE OF RETURN TO COUNTRY <i>None</i>	
91. DATE OF DEPARTURE FROM STATE <i>None</i>		92. DATE OF RETURN TO STATE <i>None</i>		93. DATE OF DEPARTURE FROM COUNTRY <i>None</i>	
94. DATE OF RETURN TO COUNTRY <i>None</i>		95. DATE OF DEPARTURE FROM STATE <i>None</i>		96. DATE OF RETURN TO STATE <i>None</i>	
97. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		98. DATE OF RETURN TO COUNTRY <i>None</i>		99. DATE OF DEPARTURE FROM STATE <i>None</i>	
100. DATE OF RETURN TO STATE <i>None</i>		101. DATE OF DEPARTURE FROM COUNTRY <i>None</i>		102. DATE OF RETURN TO COUNTRY <i>None</i>	

1. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

2. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

3. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

4. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

5. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

6. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

7. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

8. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

9. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

10. I hereby certify that the foregoing is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the day and date above written.

7684

CERTIFICATE OF DEATH

07790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1300 Poplar Ave</u>				d. STREET ADDRESS <u>Poplar Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Charles T. Shek</u> First Middle Last				4. DATE OF DEATH <u>July 2, 1960</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/19/1867</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>York Pa</u>	
12. FATHER'S NAME <u>Fredrick G. Shek</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Kease</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mary M. Shek</u> Address <u>1300 Poplar Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Cardiac failure, chronic</u> DUE TO (c) <u>Arteriosclerosis, generalised</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 15, 1960</u> , to <u>July 2, 1960</u> , that I last saw the deceased alive on <u>July 1, 1960</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. P. Williamson</u> M.D.				DATE SIGNED <u>7/3/60</u>			
PHYSICIAN'S NAME (Type) <u>E. P. WILLIAMSON</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-5-60</u>		<u>London Park</u>		<u>Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Giffert</u> ADDRESS <u>1300 Euterus Pl.</u>				24a. REC'D BY REGISTRAR DATE <u>5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Walter S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07791

7677

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN 1b 53 Dundalk (22)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 30 Flagship Road				d. STREET ADDRESS 30 Flagship Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN OSCAR SKILES				4. DATE OF DEATH Month July Day 8th Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12, 1895		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 6 Days 12	IF UNDER 24 HRS. Hours 12 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Chemical Eng.		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Skiles				14. MOTHER'S MAIDEN NAME Rachel Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-079-372		17. INFORMANT Mrs. A.N. Mumper		Address 116 Bayside Drive Baltimore 22, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Occ. lesion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 7-1 , 19 60 , to 7-8 , 19 60 ; that I last saw the deceased alive on 7-1 , 19 60 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Jack C. Collins M.D. 2 Kinship Road 7/11/60 PHYSICIAN'S NAME (Type) Jack C. Collins, M.D. Baltimore 22, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/12/60		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Meta Brooks Bradley, Inc.				ADDRESS Dundalk 22, Md.		24a. REC'D BY REGISTRAR DATE JUL 12 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

510

878 240 145

7809

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1422 Burton Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>W.</u> Last <u>Slaymaker</u>		4. DATE OF DEATH <u>July 31, 1960</u> Month <u>July</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 30, 1924</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Black and Decker</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Slaymaker</u>		14. MOTHER'S MAIDEN NAME <u>Esther Laird</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Edna J. Slaymaker</u>		Address <u>1422 Burton Ave. Luth.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GLIOMA, FRONTAL, MALIGNANT</u> <u>1939</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JAN</u> 19 <u>60</u> , to <u>JULY</u> 19 <u>60</u> , that I last saw the deceased alive on <u>JULY 28</u> 19 <u>60</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Timonium, Md</u> DATE SIGNED <u>8-1-60</u>			
ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.		PHYSICIAN'S NAME (Type) <u>William A. Pillsbury</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/4/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Gardens</u>	22d. LOCATION (City, town, or county) (State) <u>Timonium, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Towson, Inc.</u> ADDRESS <u>York Rd. Towson 4, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 3 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7810

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07793

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 33 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 902 Harlem Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PERCY Middle S. Last SMITH		4. DATE OF DEATH Month JULY Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 21, 1894
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat Store	
11. BIRTHPLACE (State or foreign country) Westchester, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel H. Smith		14. MOTHER'S MAIDEN NAME Alice (Maiden Name Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 217-16-4587	
17. INFORMANT Clin. Records, Vet. Adm. Hosp. Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF STOMACH			
INTERVAL BETWEEN ONSET AND DEATH 4 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 10 (this hospital) attended the deceased from June 28 19 60 to July 31 19 60 , that x (we) last saw the deceased alive on July 31 19 60 and that death occurred at 4:40 AM on the date stated above.			
22a. SIGNATURE John K Ebling		22b. DATE SIGNED 7/31/60	
22c. PHYSICIAN'S NAME (Type) JOHN K. EBLING, M.D.		22d. ADDRESS Veterans Adm. Hosp. Balto. Md. Ft. Howard Div	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/3/60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Roland Brown		25a. REC'D BY REGISTRAR 4 25b. REGISTRAR'S SIGNATURE Robert E. Kraus	

Roland Brown Funeral Home, 108 W. Montgomery St. Baltimore, Md.

0779

CERTIFICATE OF MARRIAGE

7810



State of Maryland
County of Prince George's
I, the undersigned, Clerk of the Circuit Court for said County, do hereby certify that on the 21st day of July, 1960, at the City of Alexandria, Virginia, the within named parties were by me lawfully joined in Holy Matrimony according to the rites and ceremonies of the Anglican Episcopal Church of America, as the same are contained in the Book of Common Prayer, as read and explained by the officiating clergyman, and in the presence of the witnesses named in the foregoing certificate, and in the presence of a sufficient number of persons to constitute a congregation.

Given under my hand and the seal of said Court, at the City of Alexandria, Virginia, this 21st day of July, 1960.
Clerk of the Circuit Court for Prince George's County, Maryland.
John E. Smith, Clerk of the Circuit Court for Prince George's County, Maryland.



CERTIFICATE OF MARRIAGE

State of Maryland
County of Prince George's
I, the undersigned, Clerk of the Circuit Court for said County, do hereby certify that on the 21st day of July, 1960, at the City of Alexandria, Virginia, the within named parties were by me lawfully joined in Holy Matrimony according to the rites and ceremonies of the Anglican Episcopal Church of America, as the same are contained in the Book of Common Prayer, as read and explained by the officiating clergyman, and in the presence of the witnesses named in the foregoing certificate, and in the presence of a sufficient number of persons to constitute a congregation.
Given under my hand and the seal of said Court, at the City of Alexandria, Virginia, this 21st day of July, 1960.
Clerk of the Circuit Court for Prince George's County, Maryland.
John E. Smith, Clerk of the Circuit Court for Prince George's County, Maryland.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 and 5 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
<div> <div>Item 18 Film 268 8-17-60</div> <div>7811</div> <div>Item 1 Film 268 8-17-60</div> </div> <div> <div>17-60</div> <div>07794</div> </div>														
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Pr. Georges Baltimore									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonville					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berwyn									
c. LENGTH OF STAY IN 1b 2Y 10M 23D					d. STREET ADDRESS 8615 Rhode Island Avenue									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) EDWARD George			First Middle Last		4. DATE OF DEATH July 10, 1960		Month Day Year							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 19, 1930		9. AGE (In years last birthday) 29 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U S A		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME George Snyder					14. MOTHER'S MAIDEN NAME Anna Hanna									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none					17. INFORMANT George Snyder same as no 2 Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic bilateral pneumonia with foci of acute pneumonia complicating mental deficiency.														
490X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Russell S. Fisher M.D.					CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 7/11/60				
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
Address (Street, city, town, or county)														
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF July 13, 1960		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.						
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.					ADDRESS		24a. REC'D BY REGISTRAR JUL 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



7211

AMERICAN UNIVERSITY OF BEIRUT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

At the residence of the deceased, 1011 17th Street, N.W., Washington, D.C., on July 12, 1950, I examined the body of the deceased, a male, white, aged 45 years, who died of a heart attack.

The deceased was found by his wife, Mrs. Mary Smith, at 10:30 A.M. on July 12, 1950. He was lying on his back, face up, with his arms at his sides. He was wearing a white shirt and dark trousers.

There were no signs of trauma or violence. The heart was enlarged and the lungs were congested. The cause of death was atherosclerosis of the coronary arteries.

The body was found in good condition. There were no signs of decomposition. The body was buried in the family plot at the National Cemetery, Arlington, Virginia, on July 15, 1950.

Witnessed by me, the undersigned, a duly qualified medical examiner, on July 12, 1950, at Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07795

7812

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Line</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Line</u>		d. STREET ADDRESS <u>1 Main St (York Rd)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Main St. (York Rd)</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William Henry</u> Middle <u>STIFFLER</u> Last <u>STIFFLER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1905</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>	IF UNDER 24 HRS. Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Freeland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Stiffler</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Brennehan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>18409-4715</u>		17. INFORMANT <u>Mrs. Naomi Stiffler, Md. Line Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STRANGULATION by hanging</u> DUE TO (b) <u>974X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>974X</u> DUE TO (c) <u>974X</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung himself with a towel attached to a pipe</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>11:30</u> p. m. <u>7:45</u> 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Md. Line Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>A. M. France</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Rock P.R.D.3.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>	

MEDICAL CERTIFICATION

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No. 07796

7813

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville 4</u>		c. LENGTH OF STAY IN lb <u>3 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor Aged Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>C Warner Stork</u>		4. DATE OF DEATH <u>July 15 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>
13. FATHER'S NAME <u>William Stork</u>		14. MOTHER'S MAIDEN NAME <u>Clintonia Warner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Pulmonary Edema, massive hemorrhage from bladder</u> DUE TO (c) <u>Arterio Sclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>about 25 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		

21. I certify that I attended the deceased from Oct 4, 1928, to July 15, 1960, that I last saw the deceased alive on July 15, 1960, and that death occurred at 2:30 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) 11 E. Chase St. DATE SIGNED 7/16/60

ACTUAL SIGNATURE Theodore H. Morrison M.D.

PHYSICIAN'S NAME (Type) Theodore H. Morrison

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc</u>		24a. REC'D BY REGISTRAR <u>Jul 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of 2

VR A15 (4)
15M 9/59

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7814

CERTIFICATE OF DEATH

07797

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 11 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 113 WELCOME ALLEY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle R Last STRANGE		4. DATE OF DEATH Month JULY Day 13 Year 1960	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 3, 1889
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) RICHMOND VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS STRANGE		14. MOTHER'S MAIDEN NAME MAGGIE CLARK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. 212 09 3901	
17. INFORMANT CLIN REC. VAH BALTO 18, MD FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL INSUFFICIENCY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF PROSTATE WITH REMOTE METASTASES DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JULY 2 19 60 to JULY 13 19 60 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on JULY 13 19 60 , and that death occurred at 2:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE C. B. COPE		22b. DATE SIGNED 7-13-60	
22c. PHYSICIAN'S NAME (Type) C. B. COPE		22d. ADDRESS VAH BALTO 18 MD - FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/18/60	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE ISAIAH I BROWN & SON		25a. REC'D BY REGISTRAR JUL 19 '60	
25b. REGISTRAR'S SIGNATURE Wm. L. Thomas			

CERTIFICATE OF DEATH

7814

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

NAME OF DECEASED

SEX

SEX

AGE

AGE

CAUSE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DIAGNOSIS

DATE OF EXAMINATION

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF EXAMINATION

DATE OF EXAMINATION

DATE OF EXAMINATION

DATE OF EXAMINATION

DATE OF EXAMINATION

DATE OF EXAMINATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7815

CERTIFICATE OF DEATH

Reg. Dist. No. 67798

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home		d. STREET ADDRESS 6734 Windsor Mill Rd.	
3. NAME OF DECEASED (Type or print) Dora Sutch		4. DATE OF DEATH Month July Day 5 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1868
9. AGE (In years last birthday) yrs. 91		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Clingman	
14. MOTHER'S MAIDEN NAME ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Irene Bartell Address 6734 Windsor Mill Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 PROTERIO SCLEROTIC CARDIO VASCULAR DISEASE DUE TO ARBTERIO SCLEROTIC CARDIO VASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY EMPHYSEMA DUE TO PULMONARY EMPHYSEMA (c) SENILITY			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/1 19 60 , to 7/5 19 60 , that I last saw the deceased alive on 7/5 19 60 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John D. Shaw M.D.		DATE SIGNED 7/6/60	
PHYSICIAN'S NAME (Type) John D. Shaw M.D.		DATE SIGNED 7/6/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 8, 1960	22c. NAME OF CEMETERY OR CREMATORY Mt. Olive	22d. LOCATION (City, town, or county) (State) Randallstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury ADDRESS 6411 Windsor Mill Rd.		24a. REC'D BY REGISTRAR DATE JUL 7 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. BIRTH COUNTRY	
JAMES H. HARRIS		Male		45		White		1880		Maryland		United States	
8. OCCUPATION		9. CAUSE OF DEATH		10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR	
Farmer		Heart Disease		Home		Jan 15, 1925		10:00 AM		[Signature]		[Signature]	
15. MANNER OF DEATH		16. PLACE OF BURIAL		17. GRAVE		18. INTERVIEWED		19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF DEPUTY REGISTRAR		21. SIGNATURE OF CLERK	
Natural		Catholic Cemetery		Lot 123		Yes		[Signature]		[Signature]		[Signature]	

1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. BIRTH DATE
6. BIRTH PLACE
7. BIRTH COUNTRY
8. OCCUPATION
9. CAUSE OF DEATH
10. PLACE OF DEATH
11. DATE OF DEATH
12. TIME OF DEATH
13. SIGNATURE OF PHYSICIAN
14. SIGNATURE OF REGISTRAR
15. MANNER OF DEATH
16. PLACE OF BURIAL
17. GRAVE
18. INTERVIEWED
19. SIGNATURE OF INTERVIEWER
20. SIGNATURE OF DEPUTY REGISTRAR
21. SIGNATURE OF CLERK

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7816

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07799

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland</u>	
c. LENGTH OF STAY IN TB <u>2 hrs.</u>		d. STREET ADDRESS <u>1 Valley Mill Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Morris Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>EUGENE</u> Last <u>SWAN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 25 1951</u>
9. AGE (In years last birthday) <u>8</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>York, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Curtis E. Swan</u>		14. MOTHER'S MAIDEN NAME <u>June A. Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Curtis C. Swan</u>		Address <u>Freeland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while bathing in a farm pond</u>	
20c. TIME OF INJURY Month, Day, Year <u>3 7/24 1960</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> <u>FARM</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>FARM</u>		20f. (City or town) <u>Freeland</u> (County) <u>PAIRO</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. M. France</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>7/24/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 26 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or county) <u>Freeland</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. France</u>	
DATE <u>JUL 27 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7817

07800

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 4 HRS 40 MIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X COCKEYSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LYOYD Middle N Last TABB		4. DATE OF DEATH Month JULY Day 6 Year 19 60					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUGUST 21 1894		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10b. KIND OF BUSINESS OR INDUSTRY ADVERTISING		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN P TABB				14. MOTHER'S MAIDEN NAME NELLIE MCKENZIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1 216-20-2905		17. INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EMPHYSEMA PULMONARY 537-1 DECK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LAENNEC'S CIRRHOSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BUERGER'S DISEASE, HISTORY OF						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from 11:00 A.M. to 3:40 P.M. 7-6-60 to 7-6-60 19____, that (I) (we) last saw the deceased alive on 7-6-60 19____, and that death occurred at 3:40 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>John K. Ebling</i> JOHN K. EBLING				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS M.D. VAH BALTIMORE 18 MD-FT HOWARD DIVISION		22b. DATE SIGNED 7-6-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 8, 1960		23c. NAME OF CEMETERY OR CREMATORY SHARON CEMETERY ADDRESS 4905 York Rd Baltimore Md		23d. LOCATION (City, town, or county) (State) MIDDLEBURG VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE Henry W Jenkins & Sons Inc				25a. REC'D BY REGISTRAR DATE JUL 8 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Huns</i>	

7818

CERTIFICATE OF DEATH

Reg. Dist. No.

07801

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i> ^{#19} MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgemere</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgemere, Balto. Co., Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>254 Oak Ave</i>		d. STREET ADDRESS <i>254 Oak Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Martha</i> Middle <i>Taylor</i> Last <i>Taylor</i>		4. DATE OF DEATH <i>July 6 - 5</i> 19 <i>60</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>10-28-05</i>
9. AGE (In years last birthday) <i>54</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Orange Co., Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George W. Davison</i>		14. MOTHER'S MAIDEN NAME <i>Martha Long</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NO</i>	
17. INFORMANT <i>Marion Hopkins, 254 Oak Ave. #19</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>331X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Hemorrhage</i> DUE TO (c) <i>7 yrs. ago.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 27, 1960</i> to <i>July 5, 1960</i> , that I last saw the deceased alive on <i>July 5, 1960</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis N. Tollin</i>		DATE SIGNED <i>6908 N. Goint Rd.</i>	
PHYSICIAN'S NAME (Type) <i>Louis N. Tollin M.D.</i>		<i>BALTO-19-md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7-8-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary</i>		22d. LOCATION (City, town, or county) (State) <i>A. A. Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>		24a. REC'D BY REGISTRAR <i>DATE JUL 7 '60</i>	
ADDRESS <i>802 Med. Ave</i>		24b. REGISTRAR'S SIGNATURE <i>Charles R. Law</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7819

CERTIFICATE OF DEATH

Reg. Dist. No.

07802

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b <u>6 yrs. 7 mos.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>				d. STREET ADDRESS <u>510 Cathedral Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Caroline</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 19, 1875</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Governess</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Carl Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Elsa T. Becker, 725 Colorado Avenue, Zone 10</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Arteriosclerotic Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Vascular</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1955</u> to <u>July 3 1960</u> that I last saw the deceased alive on <u>July 3, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles F O'Donnell</u> M.D.				ADDRESS (Street, city or town, state) <u>7501 York Rd</u> DATE SIGNED <u>7/3/60</u>			
PHYSICIAN'S NAME (Type) <u>Charles F O'Donnell</u>				<u>Towson #4 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>5839 Ritchie Highway, Zone 25</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

7820

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07803

Items 8, 9 Film G268 8-2-60 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Marsh</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 447</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>W.</u> Last <u>Thurfield</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-18-1896</u> 1895
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edgewood Ars.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Thurfield</u>		14. MOTHER'S MAIDEN NAME <u>Belle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>1918-1919</u>		16. SOCIAL SECURITY NO. <u>212263536</u>	
17. INFORMANT <u>Anna</u> Address <u>same</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shot Gun Wound - Left Chest</u> DUE TO <u>over Heart</u> Conditions, if any, which gave rise to immediate cause (b) <u>over Heart</u> (c) <u>stoting the underlying cause lost</u> DUE TO <u>over Heart</u> DUE TO <u>over Heart</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>same</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self in Heart Region @ 12 Gauge Gun</u>	
20c. TIME OF INJURY Month, Day, Year <u>2</u> Hour <u>00</u> p. m. <u>7-31</u> 19 <u>60</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>White Marsh - Baltimore Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.B. Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8-3-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>AUG 3 '60</u>	
ADDRESS <u>5305 Harford Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ACCIDENTS	
FAMILY HISTORY		SOCIAL HISTORY		OCCUPATION		EDUCATION		MARRIAGE	
SIGNED AND SWORN TO before me this _____ day of _____, 19____.		Attest:		Notary Public for Maryland		My Commission Expires _____		My Office is _____	

TO HOSE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7821

CERTIFICATE OF DEATH

Reg. Dist. No. 07804

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>173 Dumbarton Road</u>		d. STREET ADDRESS <u>173 Dumbarton Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. Paul G. Tolson</u>		4. DATE OF DEATH <u>JULY 26 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 7-1911</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vice Pres. R. E. Michel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert G. Tolson</u>		14. MOTHER'S MAIDEN NAME <u>Edith Wieland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>Mrs. Cecilia H. Tolson 173 Dumbarton Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>153.1</u> IMMEDIATE CAUSE (a) <u>Carcinoma of Transverse Colon</u> DUE TO (b) <u>Metastases to Liver & Stomach</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>8 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 15, 1959</u> , to <u>July 26, 1960</u> , that I last saw the deceased alive on <u>July 24, 1960</u> , and that death occurred at <u>3:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John A. Myers</u>		ADDRESS (Street, city or town, state) <u>104 E. Bidal St. Baltimore 2, Md.</u>	
PHYSICIAN'S NAME (Type) <u></u>		DATE SIGNED <u></u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/28/60</u>		22b. DATE THEREOF <u>7/28/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>JUL 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7822

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07805

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b <u>54</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1808 Wilson Pt. Rd.</u>		e. STREET ADDRESS <u>1808 Wilson Pt. Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES E. TROTTER</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25-1904</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Planning Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Milo H. Trotter</u>		14. MOTHER'S MAIDEN NAME <u>Manly E. Hanley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-05-7896</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occl.</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Art. Scler. Heart D.s</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 min</u> <u>5 yrs</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack E. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JACK E COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 11-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		24. REC'D BY REGISTRAR <u>Jul 12 '60</u>	
ADDRESS <u>418 Eastern Blvd. Balto. 21, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunter</u>	

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07806

7685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5713 2nd Ave</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5713 Halethorpe</u> d. STREET ADDRESS <u>5713 2nd Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
3. NAME OF DECEASED (Type or print) <u>Joseph Alphonsus Uhlhorn Sr.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>17</u> Year <u>1960</u>																													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 7, 1892</u>		9. AGE (In years last birthday) <u>68</u> yrs. <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.																
IF UNDER 1 YEAR		IF UNDER 24 HRS.																															
Months	Days	Hours	Min.																														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Brook</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>																									
13. FATHER'S NAME <u>Joseph A Uhlhorn</u>				14. MOTHER'S MAIDEN NAME <u>don't know</u>																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>W.W.</u>		17. INFORMANT Address <u>Joseph A. Uhlhorn. 5529 Council St. Arbutus</u>																											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="8"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td colspan="2" rowspan="3" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH </td> </tr> <tr> <td colspan="8"> (b) <u>Hypertensive cardio vascular disease</u> DUE TO </td> </tr> <tr> <td colspan="8"> (c) </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH		(b) <u>Hypertensive cardio vascular disease</u> DUE TO								(c)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH																									
(b) <u>Hypertensive cardio vascular disease</u> DUE TO																																	
(c)																																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																																	
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>July 17, 1960</u>																									
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>July 20-1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Balto National Cem.</u> 22d. LOCATION (City, town, or county) <u>Baltimore Md</u>																													
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kieffer</u>				ADDRESS <u>5746 Council</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kieffer</u>																									

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF ILLINOIS
DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7823

CERTIFICATE OF DEATH

07807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 19 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wladyslaw Middle Victor Last		4. DATE OF DEATH Month 7 Day 3 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 27, 1873
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) coat presser		10b. KIND OF BUSINESS OR INDUSTRY tailoring	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 211-18-2803	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome assoc. with cerebral arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 8, 1960 , to 7/3, 1960 , that I last saw the deceased alive on 7/3, 1960 , and that death occurred at 1:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE BRUNO RADDAUSKAS M.D.		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 7/3/60	
PHYSICIAN'S NAME (Type) BRUNO RADDAUSKAS		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7.7.60	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lelander & Sons - Balto.		24a. REC'D BY REGISTRAR DATE JUL 5 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Thraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7824

7

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07808

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		
d. NAME OF HOSPITAL (If not in hospital, give street address) House-In-The-Pines				d. STREET ADDRESS 1 Dogwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret E. Wahaus				4. DATE OF DEATH Month 7 Day 17 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-1869		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months 11 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME George Gettings				14. MOTHER'S MAIDEN NAME Anna D. Yeadaker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Margaret Wahaus Address Dogwood Rd; Woodlawn, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Decongenation 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Coronary Cardio Vascular Renal Disease DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 14 da. 1532 (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured Left Femur						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Falling out of bed			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Falling out of bed at her home				
20c. TIME OF INJURY Hour 3:30 p. m. Month 5 Day 16 Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore 7, Balt. Co. Md.		
21. I certify that (I) (this hospital) attended the deceased from 7-10-1960 to 7-17-1960 , that (I) (we) last saw the deceased alive on 7-16-1960 , and that death occurred at 7:55 PM , from the causes and on the date stated above.							
22a. SIGNATURE Wibner K. Gallagher			22b. DATE 7-17-60		22c. PHYSICIAN'S NAME (Type) Wibner K. Gallagher, M.D.		
22d. ADDRESS 1209 Frederick Ave., Balt-25, Md.			22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REBURYAL (Specify) Burial		23b. DATE THEREOF 7-20-1960		23c. NAME OF CEMETERY OR CREMATORY Lorraine		23d. LOCATION (City, town, or county) (State) Baltimore Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Thos. Rath + Son - 301 Federal Rd - 28			25a. REC'D BY REGISTRAR DATE JUL 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

CERTIFICATE OF DEATH

1982



WILLIAM J. HAYES

Part of the
Certificate of Death
for
Name of Deceased
Date of Death
Place of Death
Cause of Death
Age at Death
Sex
Race
Marital Status
Occupation
Education
Religion
Signature of Physician
Signature of Registrar
Date of Registration
Place of Registration
County
State

1
M
050
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
M
050
1
7825
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07809

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT HOWARD				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3515 Oakmont Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN C. WALKER				4. DATE OF DEATH Month Day Year JULY 31 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 6, 1872	
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Store (Department) Virginia			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry C. Walker				14. MOTHER'S MAIDEN NAME Margaret Doughty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) SPA AMERICAN				16. SOCIAL SECURITY NO. Clin Records, Vet. Adm Hosp, Balto, Md, Ft. Howard Div			
17. INFORMANT Clin Records, Vet. Adm Hosp, Balto, Md, Ft. Howard Div				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUODENAL ULCER WITH HEMORRHAGE. INTESTINAL OBSTRUCTION, PARTIAL CAUSE UNK				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 29 1960 to July 31 1960 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 31 1960 , and that death occurred at 10:40AM from the causes and on the date stated above.							
22a. SIGNATURE John K Ebling				22b. DATE SIGNED 7/31/60			
22c. PHYSICIAN'S NAME (Type) JOHN K. EBELING, M.D.				22d. ADDRESS VAH, BALTO. MD. - FT HOWARD DIV			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-4-60		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Mr. Cook Blight Funeral Home, 6009 Harford Rd. Balto. Md.				25a. REC'D BY REGISTRAR AUG 3 '60		25b. REGISTRAR'S SIGNATURE Clifton S. House	

0.5 m²

TABLE 1. Continued

• • •

1888

CERTIFICATE OF BIRTH

08216

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7827

07811

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 1mth16dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2411 Garrison Blvd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Grace		First Grace Middle Warfield Last Warfield		4. DATE OF DEATH Month July Day 18 Year 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1874		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records; SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) 422.01 DUE TO (c) 422.01							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gangrenous urinary cystitis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 2 1960 to July 18 1960 , that (I) (we) last saw the deceased alive on July 18 1960 , and that death occurred at 12:20 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachsler, M. D.				22b. DATE SIGNED 7-18-60		22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) 7-21-60		23b. DATE THEREOF 7-21-60		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		23d. LOCATION (City, town, or county) (State) BALTO MD	
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Rick				25a. REC'D BY REGISTRAR 5305 Hayford Rd.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
7828
07812
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH
Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60 et

1. PLACE OF DEATH a. COUNTY Maryland, Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armecost Nursing Home		d. STREET ADDRESS 1612 Bolton St.	
3. NAME OF DECEASED (Type or print) First Middle Last Kate Darby Watson		4. DATE OF DEATH Month Day Year July 15 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1874
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Darby		14. MOTHER'S MAIDEN NAME Mary K. McLean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Howard O. Buffington		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia DUE TO 174x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO years (c) Carcinoma of the uterus, Bobb's sarcoma DUE TO years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left hip - 20 APR 60		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Full getting out of bed at home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 21 APR 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore Md	
21. I certify that (I) (this hospital) attended the deceased from 25 May 1960 to 15 Jul 1960 that (I) (we) lost the deceased alive on 15 Jul 1960 , and that death occurred at 8 PM , from the causes and on the date stated above.			
22a. SIGNATURE W. F. Cox		22b. DATE SIGNED 16 Jul 60	
22c. PHYSICIAN'S NAME (Type) William F. Cox, 3rd.		22d. ADDRESS 1118 St. Paul St. Baltimore 2, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-18-60	
23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City, town, or county) (State) Ellicott City, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		25a. REC'D BY REGISTRAR DATE JUL 18 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kenna			

112215

CERTIFICATE OF DEATH

7822

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

Married

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07813

7829

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge				c. LENGTH OF STAY IN 1b X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 331 Overbrook Road				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rodgers Forge			
f. STREET ADDRESS 331 Overbrook Road				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mrs. Theresa Middle Mary Last Watson				4. DATE OF DEATH Month July Day 17 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 8, 1869	
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 91 Days 91 Hours 91 Min. 91		11. IF UNDER 24 HRS. Months 91 Days 91 Hours 91 Min. 91		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME August Weiss				14. MOTHER'S MAIDEN NAME Margaret Osche			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -----			
17. INFORMANT Mrs. Frances S. Kleiber				Address 331 Overbrook Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Generalized Hypertension DUE TO (c) Cardiovascular Disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 1956 to July 15, 1960 , that I last saw the deceased alive on July 15, 1960 , and that death occurred at 12:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. O'Donnell				ADDRESS (Street, city or town, state) 2501 York Rd 7/18/60			
PHYSICIAN'S NAME (Type) Charles F. O'Donnell				DATE SIGNED 7/18/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 21, 1960		22c. NAME OF CEMETERY OR CREMATORY St. Augustine		22d. LOCATION (City, town, or county) (State) Millvale, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home				ADDRESS 3631 Falls Road			
24a. REC'D BY REGISTRAR Jul 19 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE OFFICE OF THE ATTORNEY GENERAL

1881



12

13

14

15

16

17

18

19

20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1

7690

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07814
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Nicodemus Road		e. STREET ADDRESS Nicodemus Road	
3. NAME OF DECEASED (Type or print) First Daniel Middle W. Last Wheeler		4. DATE OF DEATH Month July Day 16 , Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1898
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School bus driver		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel W. Wheeler		14. MOTHER'S MAIDEN NAME Mary Jane Peregoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 217-07-5220	
17. INFORMANT Mrs. Hilda D. Wheeler		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) backstomach DUE TO (c) backstomach		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-30 , 19 30 , to 7-16-60 , 19 60 that I last saw the deceased alive on 7-16-60 , 19 60 and that death occurred at 145 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James G. Saffell		DATE SIGNED 7-16-60	
PHYSICIAN'S NAME (Type) James G. Saffell		ADDRESS (Street, city or town, state) Reisterstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1960	
22c. NAME OF CEMETERY OR CREMATORY Forest Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR Jul 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

7800



NAME OF DECEASED John Doe
AGE 45 SEX Male
DATE OF BIRTH Jan 15 1933
PLACE OF BIRTH San Antonio, Texas
OCCUPATION Teacher
CAUSE OF DEATH Heart Disease
DATE OF DEATH Jan 20 1978
PLACE OF DEATH San Antonio, Texas
SIGNATURE OF PHYSICIAN [Signature]
DATE Jan 20 1978

[Handwritten signature]

[Faint, mostly illegible text and signatures at the bottom of the page, possibly including a registrar's signature and date.]

1
M
7830
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
07815

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 83 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLIS Middle ---- Last WHITE				4. DATE OF DEATH Month July Day 1 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 17, 1913	
9. AGE (In years lost birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman - Laborer				10b. KIND OF BUSINESS OR INDUSTRY Nautical (Port)		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Ben Perry				14. MOTHER'S MAIDEN NAME Rosanna Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II 218-10-2984			
17. INFORMANT Clinical Rec., VAH, Baltimore 18, Md. Ft. Howard Div.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT LUNG (REMOVED 1958) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC CARCINOMA TO PARIETAL PLEURA, MEDIASTINAL LYMPH NODES, PERICARDIUM, MYOCARDIUM, RIGHT LUNG & ADRENALS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CACHEXIA INTERVAL BETWEEN ONSET AND DEATH 2 1/2 YRS 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from April 9 19 60 , to July 1 19 60 , that (X) (we) lost the deceased alive on July 1 19 60 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Charles Allen				22b. DATE SIGNED 7/1/60			
22c. PHYSICIAN'S NAME (Type) CHARLES ALLEN, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIV.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 7, 1960		23c. NAME OF CEMETERY OR CREMATORY Baltimore Mt. Auburn Cemetery, Baltimore, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips 1808 N. Monroe St. Baltimore 17, Md.				25a. REC'D BY REGISTRAR JUL 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

BP

1952]

• THE CHANGING FACE OF THE AMERICAN CITY

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7831

07816

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edmonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edmonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Summit Home</u>				d. STREET ADDRESS <u>116 Park Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Emma I White</u> First Middle Last				4. DATE OF DEATH <u>July 10 1960</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years lost birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eddy mfg.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind.</u>		11. BIRTHPLACE (State or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>J. Bowling</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Melvin S. White</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Hypostatic Pneumonia</u> <u>442X</u> DUE TO (b) <u>Cardio-Vascular Renal Disease &</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture left femur 2/14/60</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>20 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/4</u> <u>1936</u> to <u>7/10</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>7/7</u> <u>1960</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Edith W. Johnson</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>E.W. JOHNSON</u>	
22d. ADDRESS <u>3432 FREDERICK AVE 29</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/13/60</u>		<u>Landon Park</u>		<u>Balto. Ind.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Platt & Son 28</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

M

1

1

1881

(1)

[Faint, illegible handwritten text, likely a birth or death record, covering the majority of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7691

CERTIFICATE OF DEATH

Reg. Dist. No. 07817

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14 Ames Place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rebecca Middle Jane Last White				4. DATE OF DEATH Month July Day 5 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1868	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Virginia			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Mason				14. MOTHER'S MAIDEN NAME Julia Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Mary Ross, 14 Ames Place, Glyndon, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Umbilical Hernia							
INTERVAL BETWEEN ONSET AND DEATH 2 mos. 1 yr.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) none				(County)		(State)	
21. I certify that I attended the deceased from 7-17-59 , 19____, to 7-5-60 , 19____, that I last saw the deceased alive on 7-3-60 , 19____, and that death occurred at 7 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 7-5-60							
ACTUAL SIGNATURE D. D. Caples M.D.				PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
REISTERSTOWN, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley				ADDRESS Dundalk 22, Md.		24a. REC'D BY REGISTRAR DATE JUL 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07818

7832

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>301 W. Chesapeake Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>G</u> Middle <u>Zellers</u> Last		4. DATE OF DEATH <u>July</u> Month <u>6</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1882</u> 9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Catherine O'Brian</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MRS Isabelle Clark</u> Address <u>1111 Overbrook Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiovascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease > 15 yrs.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>59</u> , to <u>July 6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 6</u> , 19 <u>60</u> , and that death occurred at <u>10:30</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1211 NORTHERN PKWY. BALTO. 12, MD</u> DATE SIGNED <u>7/6/60</u>			
ACTUAL SIGNATURE <u>Robert W. Gebhardt M.D.</u>		PHYSICIAN'S NAME (Type) <u>ROBERT W. GEBHARDT</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 9, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHOLICAL</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans & Son</u>		ADDRESS <u>8802 Hartford Rd</u>	
24a. REC'D BY REGISTRAR <u>JUL 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2032

(M)

(1)

Name of deceased [Illegible]		Sex [Illegible]		Age [Illegible]	
Date of death [Illegible]		Time of death [Illegible]		Place of death [Illegible]	
Cause of death [Illegible]		Immediate cause [Illegible]		Contributing cause [Illegible]	
Nature of disease [Illegible]		Duration of disease [Illegible]		Date of onset [Illegible]	
Name of physician [Illegible]		Name of coroner [Illegible]		Name of registrar [Illegible]	
Signature of physician [Illegible]		Signature of coroner [Illegible]		Signature of registrar [Illegible]	
Date of certificate [Illegible]		Time of certificate [Illegible]		Place of certificate [Illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7833

CERTIFICATE OF DEATH

07819

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT HOWARD				c. LENGTH OF STAY IN lb 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Served as: Albert ALBERT Middle W Last ZIEMAN ZIEMANN				4. DATE OF DEATH Month July Day 29 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1893	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION CO		11. BIRTHPLACE (State or foreign country) WOODLAWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Ziemann				14. MOTHER'S MAIDEN NAME Emma Felgner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW I 215-09-7528		17. INFORMANT Address Clin. Rec. VAH Balto 18, Md Ft Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE GASTROINTESTINAL HEMORRHAGE DUE TO ACUTE MYELOID LEUKEMIA Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) 204.2						INTERVAL BETWEEN ONSET AND DEATH 1 Week 14 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 27 8:18 60 to July 29 8:20A 60 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 29 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE [Signature]		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/29/60			
22c. PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI,		22d. ADDRESS VAH Ft Howard Div. Balto 18, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-1-60	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town, or county) (State) Balto. Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight ADDRESS 6009 Harford Rd Balto Md			25a. REC'D BY REGISTRAR AUG 3 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

MEDICAL CERTIFICATION

BP

1837

1837

1837

1837

1837

1837

1837